

PATIENT HISTORY FORM

NAME _____

DATE _____

CHIEF COMPLAINT :

In your own words, why are you seeing the doctor today:

How long has this problem been present?

Have recent tests been performed for this problem (X-rays, urine cultures, blood tests)

What facility were these tests performed at? _____

PAST MEDICAL AND SOCIAL HISTORY :

Do you currently smoke? _____ yes _____ no How many packs? _____ How many years? _____

Have you ever smoked? _____ yes _____ no How many packs? _____ How many years? _____

Have you ever quit smoking _____ yes _____ no For how long? _____

Marital Status _____ single _____ married _____ widowed _____ divorced

Children _____ yes _____ no How many? _____

Do you drink alcohol? _____ Never _____ Rarely _____ Moderately _____ Heavy

Occupation? _____

ALLERGIES TO MEDICATIONS AND REACTIONS :

CURRENT PRESCRIPTION MEDICINES YOU TAKE ON A REGULAR BASIS:

LIST AND DATE ANY PREVIOUS SURGERIES YOU HAVE HAD :

DOES ANYONE IN YOUR IMMEDIATE FAMILY HAVE?

(PLEASE CIRCLE)

- | | | |
|---|---|-------------------------------------|
| <input type="radio"/> Diabetes | <input type="radio"/> Bladder Cancer | <input type="radio"/> Tuberculosis |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Prostate Cancer | <input type="radio"/> Heart Disease |
| <input type="radio"/> Kidney Stones | <input type="radio"/> Colon/Rectal Cancer | <input type="radio"/> Other: _____ |

REVIEW OF SYSTEMS

AS PART OF YOUR CURRENT PROBLEM DO, YOU HAVE:

	YES	NO
CONSTITUTIONAL SYMPTOMS		
FEVER/CHILLS/SWEATS		
TIRED		
HEADACHES		

	YES	NO
CONSTITUTIONAL SYMPTOMS		
FEVER/CHILLS/SWEATS		
TIRED		
HEADACHES		

DO YOU HAVE NOW OR HAVE YOU EVER HAD:

	YES	NO
ALLERGIC/IMMUNOLOGIC		
HAYFEVER		
DRUG ALLERGIES		
OTHER		
ENDOCRINE		
THYROID PROBLEMS		
DIABETES		
HORMONE IMBALANCE		
TIRED/SLUGGISH		
HOT FLASHES		
OTHER		

	YES	NO
GASTROINTESTINAL		
ABDOMINAL PAIN		
NAUSEA/VOMITING/BLOOD		
INDIGESTION/HEARTBRUN		
CONSTIPATION		
DIARRHEA		
OTHER		
RESPIRATORY		
WHEEZING		
FREQUENT COUGH		
SHORTNESS OF BREATH		
OTHER		

HAVE YOU EVER BEEN TREATED FOR:

	YES	NO
INIEGUMENTARY		
SKIN RASH		
BOILS		
PERSISTENT ITCH		
OTHER		
MUSCULOSKELETAL		
JOINT PAIN		
NECK PAIN		
BACK PAIN		
OTHER		
EYES		
BLURRED VISION		
DOUBLE VISION		
EYE PAIN		
OTHER		
EAR/NOSE/THROAT		
EAR INFECTION		
SORE THROAT		
SINUS PROBLEMS		
NOSE BLEEDS		
OTHER		
GENITOURINARY		
URINARY RETENTION		
PAINFUL RETENTION		
URINARY FREQUENCY		
BLOOD IN URINE		
OTHER		

	YES	NO
HEMATOLOGIC/LYMPHATIC		
SWOLLEN GLANDS		
BLOOD CLOTTING PROBLEMS		
OTHER		
CARDIOVASCULAR		
CHEST PAIN		
HEART ATTACK		
VARICOSE VEIN		
HIGH BLOOD PRESSURE		
PATIGUE		
IRREGULAR HEARTBEAT		
SHORTNESS OF BREATH		
OTHER		
NEUROLOGIC		
TREMORS		
DIZZY SPELLS		
NUMBNESS/TINGLING		
SEIZURES		
STROKES		
PASSING OUT		
OTHER		
PSYCHOLOGICAL		
DEPRESSION		
ANXIETY		
MENTAL ILLNESS		
OTHER		

NO CHANGE PREVIOUS VISIT ON _____

REVIEWED BY : _____

DATE: _____