

PATIENT HISTORY FORM

TODAY'S DATE ____/____/____ DATE OF LAST PHYSICAL EXAM ____/____/____

LAST NAME _____ FIRST NAME: _____

SOCIAL SECURITY NO. _____ DATE OF BIRTH: ____/____/____ AGE: ____ MALE

CHIEF COMPLAINT: (What is the main reason for your visit today? Describe your problem in detail) FEMALE

History of Present Illness

Please answer the following questions

Location of the problem

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other _____

Does anything help or make the problem worse?

Moving around Standing up Lying on my side

Other _____

How long does the problem last?

30 minutes 1 hour It is always there

Other _____

Is anything else occurring at the same time?

Blood in urine Burning Trouble voiding Incontinence

Other _____

Is the problem constant or variable?

Does the problem interfere with your normal functions?

Yes No If yes, please explain

Physician Comments / Notes:

Past Medical, Family & Social History

List any personal past illness and or surgeries and when they occurred.

Family History: List all serious illnesses in your immediate family. (Diabetes, prostate cancer, heart disease, etc.)

Do you have allergies? Yes No (If Yes, please explain)

Are you on a special Diet? Yes No (If Yes, explain) _____

Occupation: _____ **Marital Status:** _____

Do you smoke? Yes No

If yes, how much? _____

Do you drink Alcohol? Yes No

If yes, how much? _____

Do you exercise regularly? Yes No

Do you use drugs? Yes No

Are you currently taking any medication, prescribed or over the counter? If Yes, please list all.

Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Yes** or **No**.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other _____		

Allergic/Immunologic

Hay Fever	Y	N
Drug allergies	Y	N
Other _____		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other _____		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other _____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other _____		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other _____		

Physician use only: (Comments/Notes)

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other _____		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other _____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problem	Y	N
Other _____		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other _____		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other _____		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other _____		

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other _____		

# Answer	Level of Service
0 - 1	1 or 2
2-9	3
10+	4 or 5

Physician: _____ Date: _____