

PATIENT HISTORY FORM

Note: this is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

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

LAST NAME _____ FIRST NAME _____ MI _____

SOCIAL SECURITY No. _____ DATE OF BIRTH _____/_____/_____

CHIEF COMPLAINT

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

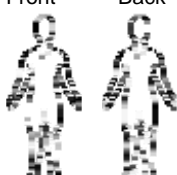
HISTORY OF PRESENT ILLNESS

Please answer the following questions

Location of the problem? (please circle)

Abdomen Back Leg Front Back

Other _____



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? (please circle)

30 minutes 1 hour It is always there

Other _____

Is anything else occurring at the same time?

Yes No If yes, please explain

Nausea Rash Headaches
Other _____

Is the problem constant or variable?

Dull then Sharp Very Sharp then leaves Always there

Other _____

Does the problem interfere with your normal functions?

Yes No If yes, please explain

<p>New Patient</p> <table style="width: 100%;"> <tr> <td># Answers</td> <td>Level</td> </tr> <tr> <td>1-3</td> <td>1 or 2</td> </tr> <tr> <td>4+</td> <td>3 - 5</td> </tr> </table>	# Answers	Level	1-3	1 or 2	4+	3 - 5	<p>Established Patient</p> <table style="width: 100%;"> <tr> <td># Answers</td> <td>Level</td> </tr> <tr> <td>1 - 3</td> <td>2 or 3</td> </tr> <tr> <td>4+</td> <td>4 or 5</td> </tr> </table>	# Answers	Level	1 - 3	2 or 3	4+	4 or 5
# Answers	Level												
1-3	1 or 2												
4+	3 - 5												
# Answers	Level												
1 - 3	2 or 3												
4+	4 or 5												

PAST MEDICAL, FAMILY & SOCIAL HISTORY

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.,)

List any personal past illness and/or Surgeries and when they occurred.

<u>Illness or Surgery</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____

Are you on a special diet? Yes No If yes, please explain)

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

Do you smoke? Yes No Do you drink? Yes No Do you exercise regularly? Yes No
If yes, how much? _____ If yes, how much? _____ If yes, how much? _____

Are you currently taking any medication? If Yes, please list all.

<p>New Patient</p> <table style="width: 100%;"> <tr> <td># Answers</td> <td>Level</td> </tr> <tr> <td>0</td> <td>1 or 2</td> </tr> <tr> <td>1 - 2</td> <td>3</td> </tr> <tr> <td>3</td> <td>4 or 5</td> </tr> </table>	# Answers	Level	0	1 or 2	1 - 2	3	3	4 or 5	<p>New Patient</p> <table style="width: 100%;"> <tr> <td># Answers</td> <td>Level</td> </tr> <tr> <td>0</td> <td>1 - 3</td> </tr> <tr> <td>1</td> <td>4</td> </tr> <tr> <td>2 - 3</td> <td>5</td> </tr> </table>	# Answers	Level	0	1 - 3	1	4	2 - 3	5
# Answers	Level																
0	1 or 2																
1 - 2	3																
3	4 or 5																
# Answers	Level																
0	1 - 3																
1	4																
2 - 3	5																

REVIEW OF SYSTEMS

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

<p>Constitutional Symptoms</p> <p>Fever Y N</p> <p>Chills Y N</p> <p>Headache Y N</p> <p>Other _____</p> <hr/> <p>Eyes</p> <p>Blurred vision Y N</p> <p>Double vision Y N</p> <p>Pain Y N</p> <p>Other _____</p> <hr/> <p>Allergic/Immunologic</p> <p>Hay Fever Y N</p> <p>Drug Allergies Y N</p> <p>Other _____</p> <hr/> <p>Neurological</p> <p>Tremors Y N</p> <p>Dizzy Spells Y N</p> <p>Numbness/Tingling Y N</p> <p>Other _____</p> <hr/> <p>Endocrine</p> <p>Excessive thirst Y N</p> <p>Too Hot/Cold Y N</p> <p>Tired/Sluggish Y N</p> <p>Other _____</p> <hr/> <p>Gastrointestinal</p> <p>Abdominal Pain Y N</p> <p>Nausea/vomiting Y N</p> <p>Indigestion/Heartburn Y N</p> <p>High Blood Pressure Y N</p> <p>Other _____</p> <hr/> <p>Cardiovascular</p> <p>Chest Pain Y N</p> <p>Varicose Veins Y N</p> <p>High Blood Pressure Y N</p> <p>Other _____</p>	<p>Integumentary</p> <p>Skin Rash Y N</p> <p>Boils Y N</p> <p>Persistent Itch Y N</p> <p>Other _____</p> <hr/> <p>Musculoskeletal</p> <p>Joint Pain Y N</p> <p>Neck Pain Y N</p> <p>Back Pain Y N</p> <p>Other _____</p> <hr/> <p>Ear/Nose/Throat/Mouth</p> <p>Ear Infection Y N</p> <p>Sore Throat Y N</p> <p>Sinus Problem Y N</p> <p>Other _____</p> <hr/> <p>Genitourinary</p> <p>Urine Retention Y N</p> <p>Painful Urination Y N</p> <p>Urinary Frequency Y N</p> <p>Other _____</p> <hr/> <p>Respiratory</p> <p>Wheezing Y N</p> <p>Frequent Cough Y N</p> <p>Shortness of Breath Y N</p> <p>Other _____</p> <hr/> <p>Hematologic/Lymphatic</p> <p>Swollen Glands Y N</p> <p>Blood Clotting Problem Y N</p> <p>Other _____</p> <hr/> <p>Psychologic</p> <p>Are you generally satisfied with your life? Y N</p> <p>Do you feel severely depressed? Y N</p> <p>Have you considered suicide? Y N</p> <p>Other _____</p>
--	--

Physician Use Only: (Comments/Notes)

<u>New Patient</u>	
<u># Answer</u>	<u>Level</u>
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

<u>Established Patient</u>	
<u># Answer</u>	<u>Level</u>
0	1 or 2
1	3
2 - 9	4
10+	5

Physician: _____

Date: _____