

Patient History Form

Note: This is a confidential record and will be kept in your doctor's office.
Information obtained 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 _____ Middle _____

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
Abdomen _____ Back _____ Leg _____
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?
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. _____

Physician use only: (Comments/Notes)

# Answers	Level of Service
1 - 3	1 or 2
4+	3 - 5

Past Medical & Social History

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

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery	Date
_____	_____
_____	_____
_____	_____

Are you on any medications? Y N (if yes, list all.)

Are you on a special diet? Y N (if yes, please explain.)

Do you smoke? Y N
If yes, how much? _____

Do you have allergies? Y N (if yes, please explain.)

Do you drink? Y N
If yes, how much? _____

Physician use only: (Comments/Notes)

# Answers	Level of Service
0	1 or 2
1 - 2	3
3	4 or 5

Review of Systems

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

Please explain any **Yes** answers in space provided

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 _____		

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 problems		
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 _____		

Physician use only: (Comments/Notes)

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

Physician: _____

Date _____/_____/_____