

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 _____ MIDDLE _____

Social Security No. _____ DATE OF BIRTH ____/____/____

CHIEF COMPLAINT

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

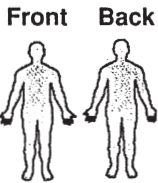
History of Present Illness

Please answer the following questions

Location of the problem

Abdomen _____ Back _____ Leg _____

Other _____



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 _____

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 _____

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 have allergies? Y _____ N _____ (If yes, Please explain.)

Do you smoke? Y _____ N _____

If yes, how much? _____

Do you drink? Y _____ N _____

If yes, how much? _____

Physician use only: (Comments/Notes)

#Answer	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 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 _____

Physician use only: (Comments/Notes)

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

Physician: _____

Date: ____ / ____ / ____