

# 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 \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## Chief Complaint

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

Right Handed?

Left Handed?

## History of Present Illness

Please answer the following questions

### Location of the problem

Abdomen \_\_\_\_\_ Back \_\_\_\_\_ Leg \_\_\_\_\_  
Other \_\_\_\_\_  
\_\_\_\_\_

Front Back



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 \_\_\_\_\_ Other \_\_\_\_\_

### PHYSICIAN USE ONLY: (Comments/Notes)

#Answer	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
_____	_____
_____	_____

Do you use tobacco? Yes No (If yes, how much)

Do you drink? Yes No (If yes, how much)

Are you on any medications? Please List \_\_\_\_\_ Dose \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Do you have seasonal/environmental allergies? Yes No

Do you use recreational drugs? Yes No

OVER

### PHYSICIAN USE ONLY: (Comments/Notes)

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

NAME \_\_\_\_\_

# Review of Systems

Have you had a bone density test within the past two years? **Circle YES or NO.**

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

**Please explain any YES answers in the 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 (Please List)	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: \_\_\_\_/\_\_\_\_/\_\_\_\_