# PATIENT HISTORY FORM

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**

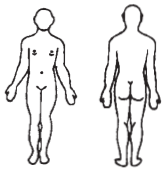
Abdomen Back Leg

Other _____

_____

_____

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 alway 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)**

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

## PAST MEDICAL AND 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 smoke?** ❑ **Y** ❑ **N** If yes, how much? _____

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

**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.

_____

_____

## REVIEW OF SYSTEMS

Do you now of have you had any problems related to the following systems. Mark 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 | ❑ 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/Vomitting | ❑ Y | ❑ N |
| Indigestion/Heartburn | ❑ Y | ❑ N |

Other _____

**Cardiovascular**

| | | |
|---|---|---|
| Chest Pain | ❑ Y | ❑ N |
| Vericose 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 Infectin | ❑ 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)**

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

Physician: _____