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 you authorization to do so.

TODAY'S DATE ______/______/______ DATE OF LAST PHYSICAL EXAM ______/______/______ CHART NO. __________

LAST NAME __________________ FIRST NAME __________________ MIDDLE __________

DATE OF BIRTH ______/______/______ REFERRING PHYSICIAN: __________________

CHIEF COMPLAINT

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

History of Present Illness

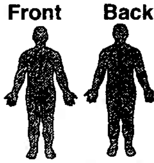
Please answer the following questions

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 described 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 leave 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**

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.)**

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**.

Constitutional Symptoms					
Fever	Y	N	Headache	Y	N
Chills	Y	N	Other ______		
Eyes					
Blurred Vision	Y	N	Double Vision	Y	N
Pain	Y	N	Other ______		
Ear/Nose/Throat/Mouth					
Ear infection	Y	N	Sinus problems	Y	N
Sore throat	Y	N	Other ______		
Respiratory					
Wheezing	Y	N	Shortness of breath	Y	N
Frequent cough	Y	N	Other ______		
Gastrointestinal					
Abdominal Pain	Y	N	Indigestion/Heartburn	Y	N
Nausea/Vomiting	Y	N	Other ______		
Genitourinary					
Urine retention	Y	N	Urinary frequency	Y	N
Painful urination	Y	N	Other ______		
Musculoskeletal					
Joint pain	Y	N	Back Pain	Y	N
Neck pain	Y	N	Other ______		
Integumentary					
Skin rash	Y	N	Boils	Y	N
Persistent itching	Y	N	Other ______		
Neurological					
Tremors	Y	N	Numbness/tingling	Y	N
Dizzy spells	Y	N	Other ______		
Endocrine					
Excessive thirst	Y	N	Tired/sluggish	Y	N
Too hot/cold	Y	N	Other ______		
Cardiovascular					
Chest Pains	Y	N	Varicose veins	Y	N
High blood Pressure	Y	N	Other ______		
Hematologic/Lymphatic					
Swollen glands	Y	N	Blood clotting problem	Y	N
Other ______					
Allergic/Immunologic					
Hay Fever	Y	N	Drug allergies	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 ______					

Please explain any Yes answers here.

Physician use only: (Comments/Notes)

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

Physician: ______ Signature: ______ Date: ___/___/___

SHELLEY X5966