# 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

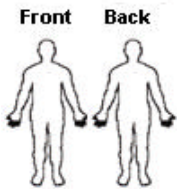
**Location of the problem**

Abdomen Back Leg

Other _____

_____

_____




**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?**

**Y**es **N**o If yes, pleases 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?**

**Y**es **N**o If yes, please explain _____

_____

| **Physician use only: (Comments/Notes)** | # Answers<br>1 – 3<br>4+ | Level of Service<br>1 or 2<br>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)** | #Answer<br>0<br>1 – 2<br>3 | Level of Service<br>1 or 2<br>3<br>4 or 5 |
|---|---|---|

# Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o.

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 heat | 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 _____ | | |

**Hematological/Lymphatic**

| | | |
|---|---|---|
| Swollen glands | Y | N |
| Blood clotting problems | 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: _____/_____/_____