

# PATIENT HISTORY FORM

(Please fill out both sides)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Family or Referring Doctor: \_\_\_\_\_

## HISTORY OF PRESENT ILLNESS

CHIEF COMPLAINT (What is the main reason for your visit today?) \_\_\_\_\_

List location and timing of problem, date of onset, modifying factors (actions which make problem better or worse), and associated symptoms (if applicable): \_\_\_\_\_

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  
Does this problem interfere with your daily activities? Y / N work? Y / N

## PAST MEDICAL, FAMILY, AND SOCIAL HISTORY

List all serious illnesses including hospitalizations:

None \_\_\_\_\_

List all surgeries: \_\_\_\_\_

None \_\_\_\_\_

Current medications (including over-the-counter and herbal medications):

None \_\_\_\_\_

List all drug allergies (along with reactions):

None \_\_\_\_\_

Do you smoke or have you smoked in the past? Y / N

If yes, how much? \_\_\_\_\_

Do you drink? Y / N

If yes, how much? \_\_\_\_\_

List all serious illnesses in your immediate family:

None \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Females: Are you pregnant? Y/N How many pregnancies? \_\_\_\_\_

Vaginal \_\_\_\_\_ C-Section \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_

In addition to the above, have you ever been diagnosed with:

(Circle yes (Y) or no (N); may place long circle around no answers if appropriate)

Y	N	Urinary Tract Infections	Y	N	Cancer
Y	N	Prostate Problems	Y	N	Kidney Stones
Y	N	Heart Attack	Y	N	Venereal Disease
Y	N	Heart Disease	Y	N	Heart Murmur
Y	N	Stroke	Y	N	Vascular Disease
Y	N	Blood Clots	Y	N	Diabetes
Y	N	High Blood Pressure	Y	N	Epilepsy/Seizures
Y	N	Asthma	Y	N	Emphysema
Y	N	Pneumonia	Y	N	Ulcers

Explain any "yes" answers in space provided on back

Physician use only (comments/notes):

Physicians initial and date each visit:

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

## REVIEW OF SYMPTOMS

Are you currently having problems with the following? (Circle yes (Y) or no (N); may place long circle around no answers if appropriate)

Genitourinary:	Y	N	Burning w/ urination	Gastrointestinal:	Y	N	Abdominal pain
	Y	N	Blood in urine		Y	N	Nausea / vomiting
	Y	N	Frequent urination		Y	N	Indigestion / heartburn
	Y	N	Getting up at night		Y	N	Constipation
	Y	N	Slow stream		Y	N	Blood in stool
	Y	N	Pain with intercourse		Y	N	Diarrhea
	Y	N	Leakage of urine	Eyes:	Y	N	Blurred / double vision
	Y	N	Flank Pain		Y	N	Vision changes
	Y	N	Problem with erections		Y	N	Eye pain
Constitution:	Y	N	Fever / chills	Ear/Nose/Throat:	Y	N	Earaches
	Y	N	Weight loss		Y	N	Sore throat
	Y	N	Loss of appetite		Y	N	Sinus problems
	Y	N	Night sweats	Musculoskeletal:	Y	N	Joint pain
	Y	N	Headaches		Y	N	Back pain
Cardiovascular:	Y	N	Chest pain		Y	N	Neck pain
	Y	N	High blood pressure	Neurological:	Y	N	Tremors / seizures
	Y	N	Ankle swelling		Y	N	Dizziness
Respiratory:	Y	N	Shortness of breath		Y	N	Numbness / tingling
	Y	N	Wheezing	Hematologic:	Y	N	Swollen glands
	Y	N	Chronic cough		Y	N	Easy bruising
Endocrine:	Y	N	Excessive thirst		Y	N	Bleeding problems
	Y	N	Hot / cold feeling	Psychologic	Y	N	Depression
	Y	N	Fatigue / sluggishness		Y	N	Anxiety

ALL OTHER REVIEW OF SYMPTOMS NEGATIVE

Explain any "Yes" answer in this space: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician use only (comments / notes):