

# PATIENT HISTORY FORM

This is a confidential record and will be kept in your doctor's office. This information will not be released to anyone without your authorization to do so.

**TODAY'S DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_      **DATE OF LAST PHYSICAL EXAM** \_\_\_\_/\_\_\_\_/\_\_\_\_

**LAST NAME** \_\_\_\_\_ **FIRST NAME** \_\_\_\_\_

**SOCIAL SECURITY NO.** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_      **DATE OF BIRTH** \_\_\_\_/\_\_\_\_/\_\_\_\_

**CHIEF COMPLAINT: What is the main reason for your visit today? Please describe your problems in detail.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## HISTORY OF PRESENT ILLNESS

Please answer the following questions.

<b>Location of the problem?</b> Abdomen    Back    Groin    Genitals Other _____ _____	<b>How long does the problem last?</b> 30 Minutes    1 Hour    It is always present. Other _____ _____
<b>On a scale of 1 to 10, with 10 being the most severe, circle the number that best describes the intensity of the problem.</b>  1    2    3    4    5    6    7    8    9    10	<b>Is anything else occurring at the same time?</b> No ____ Yes ____ If yes, please explain. Nausea    Rash    Fever    Chills    Headache Other _____ _____
<b>When did you first notice the problem?</b> 2 days ago    2 weeks ago    1 month ago Other _____	<b>Is the problem constant or variable?</b> Dull then Sharp    Very sharp then leaves    Always there Other _____
<b>Does anything help or make the problem worse?</b> Moving around    Standing up    Lying on your side Other _____ _____	<b>Does the problem interfere with your normal functions?</b> No ____ Yes ____ If yes, please explain below. _____ _____

## PAST MEDICAL, FAMILY & SOCIAL HISTORY

**List any personal PAST ILLNESSES and/or SURGERIES and when they occurred.** **Dates**


**List all serious illnesses in your immediate FAMILY.**      **Are you ALLERGIC to any MEDICATIONS/LATEX/DYE/IODINE? Please list below:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Did you ever smoke? No \_\_\_\_ Yes \_\_\_\_**      **Do you drink alcohol? No \_\_\_\_ Yes \_\_\_\_**      **Do you have HIV or Hepatitis? No \_\_\_\_ Yes \_\_\_\_**  
**If yes, how long? \_\_\_\_\_**      **Treated for alcoholism? No \_\_\_\_ Yes \_\_\_\_**      **If yes, please specify \_\_\_\_\_**

**Are you currently taking any MEDICATIONS/HERBS/VITAMINS? No \_\_\_\_ Yes \_\_\_\_**      **If yes, list all below:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## REVIEW OF SYSTEMS

Do you now or have you recently had any problems related to the following systems? Please circle **Yes** or **No**

### 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/too cold **Y** **N**  
 Tired/sluggish **Y** **N**  
 Other \_\_\_\_\_

### Gastrointestinal

Abdominal pain **Y** **N**  
 Nausea/vomiting **Y** **N**  
 Indigestion/heartburn **Y** **N**  
 Stool leakage **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/Note/Throat/Mouth

Ear infection **Y** **N**  
 Sore throat **Y** **N**  
 Sinus problems **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 **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 \_\_\_\_\_

### Genitourinary

Urine retention **Y** **N**  
 Painful urination **Y** **N**  
 Urinary Frequency **Y** **N**  
 Leak urine with cough/sneeze/sports **Y** **N**  
 Sudden urge to void with leakage **Y** **N**  
 Sexually transmitted disease **Y** **N**  
 If yes, please specify \_\_\_\_\_  
 Blood in urine – ever? **Y** **N**  
 Do you wear pads for leakage of urine? **Y** **N**  
 If yes, how many pads a day? \_\_\_\_\_  
 Do you change clothes for urine leakage? **Y** **N**  
 Do you need to wear diapers? **Y** **N**

### Female:

Do you still have a menstrual cycle? **Y** **N**  
 Are you currently sexually active? **Y** **N**  
 Number of pregnancies \_\_\_\_\_  
 Date of most recent PAP/Pelvic exam \_\_\_\_\_

### Male:

Trouble with erections **Y** **N**  
 Trouble with ejaculation **Y** **N**  
 Ejaculate prematurely **Y** **N**

### For Physician Use Only – NOTES:

D.O./M.D./P.A./N.P. Signature \_\_\_\_\_