

# PATIENT HISTORY FORM

Today's Date \_\_\_\_\_ Primary Care Physician \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_ Date of Birth \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_ Do not release Information to: \_\_\_\_\_

**Chief Complaint**—What is the main reason for your visit today? *(Describe your problem in detail).*

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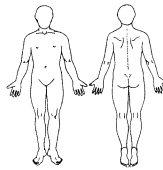
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**History of Present Illness**—Please answer the following questions.

**Location of the problem**

**Front Back**



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**On a scale of 1-10, with 10 being the most severe, circle the number that best describes the pain / problem.**

1 2 3 4 5 6 7 8 9 10

**What date did you first notice the problem?** \_\_\_\_\_

**Does anything help or make the problem worse?**

Moving around    Standing up    Lying on my side

Other \_\_\_\_\_

**Are you on medications?**  Yes  No If yes, list all.

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**Do you take over-the-counter drugs?**  Yes  No

If yes, list all.

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**How long does the pain / problem last?** \_\_\_\_\_

**Is the problem constant or intermittent?** (circle one)

Dull then sharp    Very sharp then leaves    Always there

Other \_\_\_\_\_

**Is anything else occurring at the same time?**

Yes  No If yes, please explain.

Nausea    Rash    Headaches

Other \_\_\_\_\_

**Does the problem interfere with your normal functions?**

Yes  No If yes, please explain.

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**Do you have allergies?**  Yes  No If yes, list all.

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**Latex allergies?**  Yes  No

**MRSA?**  Yes  No

**List any personal past surgeries and when they occurred.**

Surgery \_\_\_\_\_ Date \_\_\_\_\_

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**PERSONAL HISTORY**—List all serious illnesses you've had.

*(Example: diabetes, high blood pressure, breast cancer, heart disease, rheumatoid arthritis, etc.)*

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Occupation \_\_\_\_\_

Stated height: \_\_\_\_\_ Stated weight: \_\_\_\_\_

Married  Single  Divorced  Widowed

**Do you smoke?**  Yes  No If yes, how much? \_\_\_\_\_

**Are you on a special diet?**  Yes  No If yes, please explain.

**Do you drink?**  Yes  No If yes, how much? \_\_\_\_\_

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