

# PATIENT HISTORY FORM

Today's Date \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_

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

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

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

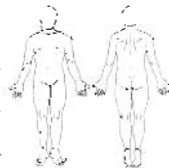
**Location of the problem**

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Front Back



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 \_\_\_\_\_

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

When did you first notice the problem? \_\_\_\_\_

Does anything help or make the problem worse?

Moving around    Standing up    Lying on my side

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.

\_\_\_\_\_

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

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Do you have allergies?  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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Latex allergies?  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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**FAMILY HISTORY**—List all serious illnesses in **your immediate family**.

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

_____	_____
_____	_____
_____	_____
_____	_____

**Review of Systems**—Do you now or have you had any problems related to the following systems? Circle Yes or No.  
Please explain any Yes answers in space provided.

**Ear/Nose/Throat/Mouth**

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

**Musculoskeletal**

Joint pain              Y    N  
Neck pain              Y    N  
Back pain              Y    N  
Other \_\_\_\_\_

**Eyes**

Blurred vision        Y    N  
Double vision        Y    N  
Pain                    Y    N  
Other \_\_\_\_\_

**Neurological**

Tremors                Y    N  
Dizzy spells           Y    N  
Numbness/tingling   Y    N  
Other \_\_\_\_\_

**Respiratory**

Wheezing              Y    N  
Frequent cough       Y    N  
Shortness of breath   Y    N  
Other \_\_\_\_\_

**Endocrine**

Excessive thirst      Y    N  
Too hot/cold          Y    N  
Tired/sluggish        Y    N  
Other \_\_\_\_\_

**Cardiovascular**

Chest pain            Y    N  
Varicose veins        Y    N  
High blood pressure   Y    N  
Swollen glands        Y    N  
Blood clotting problem Y    N  
Other \_\_\_\_\_

**Constitutional Symptoms**

Fever                   Y    N  
Chills                  Y    N  
Headache              Y    N  
Weight Loss            Y    N

**Gastrointestinal**

Abdominal pain       Y    N  
Nausea/vomiting      Y    N  
Indigestion/heartburn Y    N  
Other \_\_\_\_\_

**Integumentary**

Skin rash              Y    N  
Boils                   Y    N  
Persistent itch        Y    N  
Other \_\_\_\_\_

**Genitourinary**

Urine retention        Y    N  
Painful urination     Y    N  
Urinary frequency    Y    N  
Other \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date