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 _____/_____/_____

LAST NAME _____ FIRST NAME _____ MIDDLE _____

SOCIAL SECURITY No. _____ DATE OF BIRTH _____/_____/_____ AGE _____

REF. PHYSICIAN _____ PRIMARY PHYSICIAN _____

CHIEF COMPLAINT: What is the main reason for your visit today? (Describe your problem in detail.)

_____

_____

_____

For Physician's Use Only (4)

History of Present Illness

- ❑ Location _____
- ❑ Quality _____
- ❑ Severity _____
- ❑ Duration _____
- ❑ Timing _____
- ❑ Context _____
- ❑ Modifying Factors _____
- ❑ Associated Signs & Symptoms _____

Past Medical & Social History

Occupation _____

List all serious illnesses in your immediate family.
(Example: diabetes, cancer, heart disease)

_____

_____

_____

_____

List personal past illnesses.

_____

_____

_____

_____

List personal past surgeries.

_____

_____

_____

_____

Do you have any drug allergies ❑ Yes ❑ No
(if yes, please list all.)

_____ _____

_____ _____

_____ _____

Please list medicines you take.

_____ _____

_____ _____

_____ _____

_____ _____

Do you:

1. Consume caffeinated/soft drinks ❑ Yes ❑ No
   How much? _____
2. Consume alcohol ❑ Yes ❑ No
   How much? _____
3. Smoke ❑ Yes ❑ No
   How much? _____

For Physician's Use Only (Comments/Notes)

# Answer	Level of Service
0	1 or 2
1 - 2	3
3	4 or 5

over

Review of Systems

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

A. Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other _____

B. Eyes

Blurred Vision	Y	N
Double Vision	Y	N

Other _____

C. Allergic/Immunologic

Hay fever	Y	N
Drug allergies	Y	N

Other _____

D. Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/tingling	Y	N

Other _____

E. Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other _____

F. Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N

Other _____

G. Cardiovascular

Heart trouble	Y	N
High Blood Pressure	Y	N

Other _____

H. Integumentary

Skin Rash	Y	N

Other _____

I. Musculoskeletal

Joint Pain	Y	N
Back Pain	Y	N

Other _____

J. Ear/Nose/Throat/Mouth

Sinus Problems	Y	N

Other _____

K. Genitourinary - Male

Urine retention	Y	N
Erectile dysfunction	Y	N
Urinary frequency	Y	N

Other _____

L. Genitourinary - Female

Loss of urine/Urinary frequency	Y	N
Painful urination	Y	N
Last menstrual period Date:____/____/____		

Other _____

M. Respiratory

Frequent cough	Y	N
Shortness of breath	Y	N

Other _____

N. Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N

Other _____

O. Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N

Other _____

For Physician's Use Only (Comments/Notes)

# Answer	Level of Service
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1 - 2	3
3	4 or 5

Physician: _____ Date: ____/____/____