PATIENT HISTORY FORM

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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 _____/_____/_____ DATE OF LAST PHYSICAL EXAM _____/_____/_____

LAST NAME _____ FIRST NAME: _____

SOCIAL SECURITY NO. _____ DATE OF BIRTH: ____/_____/_____

ETHNICITY, RACE & LANGUAGE _____

REFERRING PHYSICIAN'S NAME AND ADDRESS: _____

OTHER PHYSICIANS' NAMES AND ADDRESSES: _____

_____

History of Present Illness

Please answer the following questions

What is the main reason for your visit today? (Describe in detail) _____

I seemed to be well until _____ At that time, I noticed _____

I reported this to my physician approximately _____

Other problems I reported to my physician are _____

Treatment was _____ Testing was _____

Past Medical, Family & Social History

Marital status: _____ Married _____ Single _____ Separated I was born (City, State) _____

I live with: _____ Self _____ Spouse _____ Other

Emergency Contact Person: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please list all medications you are currently taking. _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Pharmacy of Choice: _____ **Phone:** _____

Allergies: _____

Height _____ Weight _____

Primary work during adult life (if homemaker, please list): _____

If retired, what year? _____

Please circle Yes or No. Have you been exposed to:

Y N Asbestos? When/where? _____

Y N Coal? When/where? _____

Y N Radiation? When/where? _____

Y N Other toxic substances? What? _____ **When/where?** _____

List any personal past Illnesses and when they occured: _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

List any personal past surgeries and when they occured: _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Please Circle Yes or No:

Y N Have you smoked cigarettes? **How many packs per day?** _____
Y N Do you smoke them now? **Age started smoking?** _____ **Age stopped smoking?** _____

Y N Have you smoked cigars? **How many per day?** _____
Y N Do you smoke them now? **Age started smoking?** _____ **Age stopped smoking?** _____

Y N Do you drink alcohol?
Y N Have you suffered from alcoholism?
Usual alcohol consumption per day:
 # Beers: _____ **# Glasses of Wine:** _____ **# Hard drinks:** _____

FAMILY HISTORY	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				
Brother(s)				
Sister(s)				
Son(s)				
Daughter(s)				

Please write the relative's relationship next to each condition that applies. Do you know of any blood relative has or had:

_____ Stroke
_____ Cancer
_____ High blood pressure
_____ Tuberculosis
_____ Diabetes
_____ Leukemia
_____ Epilepsy
_____ Suicide
_____ Migraine
_____ Asthma
_____ Hay fever
_____ Bleeding tendency
_____ Heart attack
_____ Stomach ulcers
_____ Kidney disease
_____ Goiter
_____ Arthritis
_____ Colitis
_____ Nervous breakdown
_____ Rheumatic heart
_____ Insanity
_____ Congenital heart problem

REVIEW OF SYSTEMS

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

Constitutional Symptoms

Y N Fevers?
Y N Drenching sweats?
Y N Chills?

Y N Frequent, severe headaches?
If yes, answer the following:
Y N Do they cause visual trouble?
Y N Do they occur on one side of the head?
Y N Do they awaken you from sleep at night?
Y N Do they feel like a tight hatband?
Y N Do they hurt most in the back of the head/neck?
Y N Does aspirin relieve them?
Y N Do you have a severe backache?
Y N Do you have shoulder pain?

Eyes

Y N Blurred vision?
Y N Double vision?
Y N Eye pain?

Allergic/Immunologic

Y N Hay Fever?
Y N Drug allergies?

Neurological

Y N Fainting spells?
Y N Dizziness?
Y N Weakness of an arm or leg?
Y N Tremors?
Y N Numbness/tingling?
Y N Convulsions?

Integumentary (Skin)

Y N Skin rash?
Y N Boils?
Y N Persistent itch?
Y N Discharge or bleeding from a breast?

Musculoskeletal

Y N Pains in calves of legs when walking?
Y N Cramps in legs at night?
Y N Pain in the big toe?
Y N Swelling in the ankles?
Y N Joint pain?
Y N Back pain?
Y N Neck pain?

Ear/Nose/Throat/ Mouth

Y N Pains in ear?
Y N Ear infection?
Y N Nosebleeds?
Y N Sinus problems?
Y N Drainage in back of throat?
Y N Sore tongue?
Y N Sore throat?

Endocrine

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

Cardiovascular

Y N High blood pressure?
Y N Sleep on more than one pillow?
Y N Palpitations?
Y N Varicose veins?
Y N Phlebitis or inflamed leg veins?

Y N Chest pain/tightness in chest?
If you have had chest pain or tightness, does it
Y N Begin when exerting yourself?
Y N Begin when walking against a cold wind?
Y N Begin when walking up a hill?
Y N Begin after a heavy meal?
Y N Begin when upset or excited?
Y N Radiate down the arm?
Y N Disappear when you rest?
Y N Occur only when you rest?

Respiratory

Y N Wheezing?
Y N Chronic cough?
Y N Coughing up blood?
Y N Coughing up much sputum?

Y N Shortness of breath?
If you have shortness of breath, does it
Y N Occur when doing your usual work?
Y N Occur when climbing a flight of stairs?
Y N Awaken you at night?
Y N Cause you to cough?

Hematologic/Lymphatic

Y N Swollen glands?
Y N Blood clotting problem?

Gastrointestinal

Do you:

Y N Belch frequently?
Y N Frequently have trouble swallowing?
Y N Frequently have hoarseness?
Y N Have severe nausea and vomiting at night?
Y N Does hot water come up in mouth at night?
Y N Crampy pain in abdomen?
Y N Alternating diarrhea and constipation?
Y N Pain during or after bowel movement?
Y N Mucous in the stool?
Y N Blood in the stool?
Y N Diarrhea most of the time?
Y N Black stools?
Y N Require use of strong laxatives or enemas?
Y N Diarrhea at night?

Have you recently had pain in the stomach which:

Y N Occurs 1 – 2 hours after a meal?
Y N Is brought on by eating fried or gassy foods?
Y N Awakens you at night?
Y N Is relieved by antacid medications?
Y N Is relieved with milk or eating?
Y N Occurs while eating or immediately after?
Y N Is relieved by a bowel movement?
Y N Causes a loss of appetite?

Y N Have you had a change of weight?
If yes, how much:
Pounds Gained: _____
Pounds Lost: _____
Over how many months? _____

Psychologic

Y N Are you generally satisfied with your life?
Y N Do you feel severely depresed?
Y N Have you considered suicide?

Genitourinary

Y N Burning when urinating?
Y N Difficulty controlling your bladder?
Y N Blood in the urine?
Y N Dark colored urine?
Y N Trouble starting to urinate?
Y N Trouble holding the urine?
Y N Getting up frequently at night to urinate?
Y N Passed a kidney stone?

Questions for **MEN ONLY**:

Have you ever had:

Y N Loss of sexual activity?
If so, for how long? _____
Y N Treatment for genitals (private parts)?
Y N Discharge from penis?
Y N Hernia (rupture)?
Y N Prostate trouble?

Questions for **WOMEN ONLY**:

Age of first menstrual period: _____
Approximate date of your last period: _____
Y N Do you still have regular monthly periods?
Y N Do you ever have bleeding between periods?
Y N Do you have very heavy bleeding with periods?
Y N Are you bloated and irritable before periods?
Y N Do you take birth control pills?
Y N Have you ever taken birth control pills?
If so, when? _____
Y N Have you ever had a miscarriage? When?_____
Y N Have you ever had discharge from nipple/ breast?
Y N Do you have a regular PAP smear?
Last test: _____

How many children born alive? _____
How many miscarriages? _____
How many stillbirths? _____
How many premature births? _____
How many cesarean operations? _____
Any complications of pregnancy? _____

Physician Use Only

Physician: _____ Date: _____