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 with out your authorization

Today's Date ____/____/_____ Date of last physical Exam ____/____/_____

Last Name_____ First Name _____ Middle _____

Social Security No. _____-_____-_____ Date of Birth ____/____/____ Gender M F

Chief Complaint:

What is the main reason for your visit today (describe your problem in detail)

_____

_____

_____

History of present illness

Please answer the following questions

Problem _____ When did it start? Date _____ Wks Mths Yrs

It is always there? Y N What part of your body? _____

How severe is it? Mild Moderate Severe Have you ever had this problem in the past? Y N

Does anything help the problem? Y N If so what? _____

Does anything make the problem worse? Y N If so what? _____

Does the problem interfere with your normal functions? Y N

If Yes please explain _____

Physician use only : (Comments/Notes)

# Answers	Level of service
1 -3 or 4+	1or 2, 3 - 5

Past Medical, Family & Social History

List any personal past illness/surgeries None

_____

_____

_____

List all serious illnesses in your immediate family. None

(I.E.: Diabetes, Breast cancer, heart disease)

_____

_____

Do you have medication allergies? Y To What ? _____

Are you on any medication? None

Name of Drug	**Dose/mg**	**# times per day**

Drink Alcohol? Y N Drinks/wk

Drink Caffeine? Y N Servings/wk

Use Seatbelts? Y N

Travel Internationally? Y N

Smoke (now or past)? Y N # of years

Number of packs/day _____

Year you quit _____

Sunscreen? Rarely Occasionally Frequently

Physician use only : (Comments/Notes)

# Answers	Level of service
0, 1-2, 3	1 or 2, 3, 4-5

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 answer in space provided

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/Cold	Y	N
Tired Sluggish	Y	N

Other_____

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	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 Nose & Throat

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N

Other_____

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	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 problems	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_____

Physician use only: (Comments/Notes)

Answers	Level of service
0 - 1	1 or 2
2 - 9	3
10 +	4 or 5

Advanced Directive? Y N

Living Will Y N

Pharmacy Name:_____ **Pharmacy Phone #**_____

Pharmacy FAX #_____

Physician Signature_____ Date _____/_____/_____