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

Referring Physician_____ Primary Care Physician_____

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 1 -3 or 4+	Level of service 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 N If yes, 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 1 -3 or 4+	Level of service 1or 2, 3 - 5

Last Name_____ First Name _____ Middle _____

Review of systems

Do you now or have any of the following problems on a ongoing basis? Circle Yes or No

Please explain any yes answer in space provided

Constitutional symptoms
Weight gain of 10lb's + Y N
Frequent fever/night sweats Y N
Fatigue/weakness Y N
Other_____

Eyes
Blurred vision Y N
Double vision Y N
Other_____

Ear Nose & Throat
Difficulty hearing Y N
Sinus Problems Y N
Snoring Y N
Other_____

Respiratory
Chronic cough/blood in sputum Y N
Shortness of breath Y N
Wheezing Y N
Other_____

Cardiovascular
Palpitations/irregular heartbeat Y N
Chest pain/tighness Y N
Swelling in feet/legs Y N
Other_____

Gastrointestinal
Nausea/Vomiting Y N
Diarrhea or bleeding Y N
Constipation or use of laxitives Y N
Change in bowel habits Y N
Other_____

Genitourinary
Frequent urination Y N
Burning or pain with urination Y N
Blood in urine Y N
Other_____

Endocrine
Bothered excessively by hot/cold weather Y N
Thirsty most of the time Y N

Hematologic/Lymphatic
Bleeding/brusing easily Y N
Lumps in neck, armpits, groin Y N

Neurological
Frequent headaches Y N
Tremors Y N
Numbness/tingling Y N
Other_____

Psychiatric
Depressed or sad Y N
Nervous or anxious Y N
Attempted suicide or suicidal thoughts Y N
Other_____

Musculoskeletal
Painful or swollen joints Y N
Back pain Y N
Difficulty or pain with walking Y N
Other_____

Skin
Persistent rash Y N
Change in moles Y N
Other_____

Allergic/Immunologic
Hay Fever Y N
Drug Allergies Y N
Other_____

Physician use only : (Comments/Notes)

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

Advanced Directive? Y N Living Will Y N

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

Pharmacy FAX #_____

Physician Signature_____ Date _____/_____/_____