



PATIENT HISTORY

PATIENT NAME: _____ DATE: _____

CHIEF COMPLAINT: DESCRIBE THE PROBLEM FOR WHICH YOU ARE BEING SEEN TODAY

PLEASE LIST YOUR MEDICATIONS: _____

PLEASE LIST YOUR ALLERGIES: _____

LIST ANY PAST SURGERIES AND THE DATE OF OCCURRENCE: _____

LIST ANY MAJOR ILLNESSES OR HOSPITALIZATIONS AND THE DATE OF OCCURRENCE: _____

	<u>PERSONAL HISTORY</u>		<u>FAMILY HISTORY</u>		<u>RELATIONSHIP</u>
DIABETES	Y	N	Y	N	_____
HIGH BLOOD PRESSURE	Y	N	Y	N	_____
HEART TROUBLE	Y	N	Y	N	_____
CANCER	Y	N	Y	N	_____
STROKE	Y	N	Y	N	_____
CONVULSIONS	Y	N	Y	N	_____
ARTHRITIS/GOUT	Y	N	Y	N	_____
BLEEDING PROBLEMS	Y	N	Y	N	_____
RECURRING INFECTIONS	Y	N	Y	N	_____
VENEREAL DISEASE	Y	N	Y	N	_____
HEREDITARY DEFECTS	Y	N	Y	N	_____
HEPATITIS	Y	N	Y	N	_____

SOCIAL HISTORY:

USE OF ALCOHOL: NEVER _____ RARELY _____ MODERATE _____ DAILY _____

USE OF TOBACCO NEVER _____ PREVIOUSLY, BUT QUIT _____ CURRENT PACKS/DAY _____

USE OF DRUGS NEVER _____ TYPE/FREQUENCY _____

Patient Name: _____

Date: _____

REVIEW OF SYSTEMS : PLEASE INDICATE ANY PERSONAL HISTORY

CONSTITUTIONAL SYMPTOMS

Poor general health lately	Y	N
Recent weight change	Y	N
Fever	Y	N
Fatigue	Y	N

MUSCULOSKELETAL

Joint Pain	Y	N
Joint stiffness or swelling	Y	N
Weakness of muscles or joints	Y	N

EYES

Eye disease or injury	Y	N
Wear glasses/contact lenses	Y	N
Blurred or double vision	Y	N
Glaucoma	Y	N

INTEGUMENTARY (SKIN, BREAST)

Rash or itching	Y	N
Change in skin color	Y	N
Breast lump	Y	N
Breast discharge	Y	N
Jaundice	Y	N

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	Y	N
Earaches or drainage	Y	N
Nose bleeds	Y	N
Bleeding gums	Y	N
Sore throat or voice change	Y	N

NEUROLOGICAL

Frequent or recurring headaches	Y	N
Convulsions or seizures	Y	N
Paralysis	Y	N
Stroke	Y	N
Head injury	Y	N

CARDIOVASCULAR

Heart trouble	Y	N
Chest pain or angina pectoris	Y	N
Palpitation	Y	N
Shortness of breath with walking		
Or lying flat	Y	N
Heart valve problems	Y	N

PSYCHIATRIC

Memory loss or confusion	Y	N
Depression	Y	N

ALLERGIC/IMMUNOLOGIC

HIV	Y	N
Low white blood count	Y	N

RESPIRATORY

Chronic or frequent coughs	Y	N
Spitting up blood	Y	N
Shortness of breath	Y	N
Asthma or Wheezing	Y	N

ENDOCRINE

Glandular or hormone problem	Y	N
Thyroid disease	Y	N
Diabetes – Insulin Dependent	Y	N
Diabetes – Non-Insulin Dependent	Y	N
Excessive thirst or urination	Y	N
Hear or cold intolerance	Y	N

GASTROINTESTINAL

Loss of appetite	Y	N
Change in bowel movements	Y	N
Nausea or vomiting	Y	N
Frequent diarrhea	Y	N
Painful bowel movements	Y	N
Constipation	Y	N
Rectal bleeding or blood in the stool	Y	N
Abdominal pain	Y	N
Peptic ulcer (stomach or Duodenal)	Y	N
Heartburn	Y	N

HEMATOLOGIC/LYMPHATIC

Bleeding tendency	Y	N
Bruising tendency	Y	N
Anemia	Y	N
Past Transfusion	Y	N
Enlarged glands	Y	N

GENITOURINARY

Frequent urination	Y	N
Burning or painful urination	Y	N
Blood in urine	Y	N
Change in force of stream when		
Urinating	Y	N
Kidney stones	Y	N
Female – Irregular periods	Y	N
Last menstrual period	_____	
# of pregnancies	_____	