Consult requested by:_____

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_____/_____/_____ DATE OF LAST PHYSICAL EXAM_____/_____/_____

LAST NAME_____ FIRST NAME_____ MIDDLE_____

Social Security No. _____ DATE OF BIRTH_____/_____/_____

CHIEF COMPLAINT

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

_____

_____

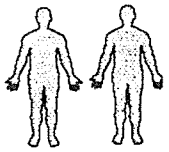
_____

History of Present Illness

Please answer the following questions

Location of the problem

Front Back



Abdomen Back Leg

Other_____

_____

_____

On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other_____

Does anything help or make the problem worse?

Moving around Standing Up Lying on my side

Other_____

How long does the problem last?

30 minutes 1 hour It is always there

Other_____

Is anything else occurring at the same time?

YES NO If yes, please explain.

Nausea Rash Headaches

Other_____

Is the problem constant or variable?

Dull then Sharp Very sharp then leaves Always there

Other_____

Does the problem interfere with your normal functions?

YES NO If yes, please explain_____

_____

Physician use only: (Comments/Notes)

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

Past Medical & Social History

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

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery **Date**

_____

_____

_____

Do you smoke? Y N

If yes, how much? _____

Do you drink? Y N

If yes, how much? _____

Are you on any medications? Y N **(If yes, list all.)**

_____ _____

_____ _____

Are you on a special diet? Y N **(If yes, please explain)**

_____

Do you have allergies? Y N **(If yes, Please explain.)**

_____

_____

Physician 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.

Please explain any Yes answers 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/Mouth

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 problem	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)

#Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician: _____ Date: _____/_____/_____