



Patient History Form

Date _____

Patient Name _____ DOB _____

Describe your main problem _____

Where is your problem located? _____

How severe is your problem? _____

How long have you had this problem? _____

When does this problem occur? _____

Where were you when this problem started? _____

What other things happen with this problem? _____

List previous Hospitalizations/Surgeries/Serious Injuries _____ When? _____

List Medications you are currently taking

Have you ever had the following?

Diabetes YES NO

Hypertension YES NO

Cancer YES NO

Stroke YES NO

Heart trouble YES NO

Arthritis/Gout YES NO

Convulsions YES NO

Bleeding tendencies YES NO

Acute infections YES NO

Venereal disease YES NO

Hereditary defects YES NO

Patient Social History

Marital Status Single Married Separated Divorced Widowed

Use of alcohol Never Rarely Moderate Daily _____

Use of tobacco Never Previously but quit Current packs per day _____

Use of drugs Never Type/Frequency _____

Allergies None Yes to medications _____

Yes to other _____

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Patient Signature _____

Physician Signature _____

Please answer all questions**Have you ever had any of the following during the past three months?****Constitutional**

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

Eyes

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

ENT

Hearing loss	No	Yes
Ringing in the ears	No	Yes
Earaches or drainage	No	Yes
Sinus problems	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

Cardiovascular

Heart trouble	No	Yes
Chest pains	No	Yes
Sudden heart beat changes	No	Yes
Swelling of feet, ankles or hands	No	Yes

Respiratory

Frequent coughing	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

Gastrointestinal

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movement/constipation	No	Yes
Blood in stool	No	Yes
Stomach pain	No	Yes

Genitourinary

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male - testicle pain	No	Yes
Female - pain with periods	No	Yes
Female - irregular periods	No	Yes
Female - vaginal discharge		
Female - # pregnancies _____ # miscarriages _____		
Female - date of last pap smear _____		
Female - findings of last pap smear <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		

Musculoskeletal

Joint Pain	No	Yes
Joint Stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

Skin

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

Neurological

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes

Psychiatric

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Sleep problems	No	Yes

Endocrine

Grandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Dry skin	No	Yes
Change in hat or glove size	No	Yes

Hematologic/Lymphatic

Slow to heal after cuts	No	Yes
Easily bruise or bleed	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged Glands	No	Yes