

PATIENT HISTORY

Name: _____ Date: _____

Occupation: _____ Age: _____ Sex: _____

REASON FOR TODAY'S VISIT:

Date of Onset: _____ Symptoms: _____

HAVE YOU SOUGHT PRIOR MEDICAL ATTENTION FOR THIS PROBLEM: Yes No

If YES, from whom: _____ Date: _____

Were x-rays taken: Yes No If Yes, what part of body?: _____

ALLERGIES (example: Latex, Shell Fish, Allergies to medication) or check: None

PAST HISTORY:

List of current Medications / Herbals and dosages or check: None

ILLNESSES: (check all that apply) Diabetes Heart Trouble Stroke Hypertension Asthma Heart Murmur
 Emphysema TB Ulcer Cancer Thyroid Hepatitis Other (please explain) _____

OPERATIONS: (check all that apply) Tonsillectomy Appendectomy Hernia Repair Hysterectomy Gallbladder
 Other (please explain) _____

TRANSFUSIONS: Yes No Please explain: _____

HOSPITALIZATIONS OTHER THAN SURGERY: Yes No Please explain: _____

FAMILY HISTORY: Age Living / Deceased Illnesses/Cause of Death

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Children: _____

HABITS: Tobacco Use: Yes No Type and Amount / Day: _____ Drink Alcohol: Yes No

REVIEW OF SYSTEMS: (Check all that apply to TODAY's visit)

General

- Weight Loss
- Weight gain
- Poor appetite
- Chills
- Fever
- Night sweats

Cardiovascular

- Chest pain (angina)
- Palpitations (rapid heartbeat)
- Irregular heartbeat (arrhythmia)
- Rheumatic fever
- Swollen ankles (pedal edema)
- Shortness of breath on exertion
- Shortness of breath at night

Gastrointestinal

- Indigestion
- Gas
- Nausea
- Vomiting
- Vomiting blood
- Yellow skin
- Abdominal pain
- Constipation
- Diarrhea
- Black stools
- Rectal bleeding

Lymphatics

- Lymph node swelling
- Node Tenderness

Endocrine

- Excessive urination
- Excessive thirst
- Excessive appetite
- Heat intolerance
- Cold intolerance

Skin

- Rash
- Hives
- Lesions

Pulmonary

- Shortness of breath
- Wheezing
- Coughing
- Coughing up blood (hematemesis)

Psychiatric

- Anxiety
- Depression
- Other _____

Neurological

- Loss of consciousness
- Headaches
- Dizziness
- Seizures (fits)
- Fainting spells

HEENT

- Hay fever
- Postnasal drip
- Hoarseness
- Visual Problems
- Hearing Loss

Genitourinary

- Frequent urination (frequency)
- Urgent urination (urgency)
- Painful urination (dysuria)
- Need to awaken to urinate
- Blood in urine
- Penile or vaginal discharge
- Kidney stone pain

FEMALES:

Are you pregnant: Yes No
Date of last menstrual cycle _____

HEIGHT: _____

WEIGHT: _____

DOMINANCE: Right Hand _____ (or) Left Hand _____

I certify that the information provided above is correct and true.

SIGNATURE: _____

DATE: _____

DATES FORM REVIEWED WITHOUT CHANGE: (please initial and date)

