# PATIENT HISTORY FORM

**BP** _____/_____ **P** _____ **R** _____ **T** _____

**Nutrition:** _____ **Grooming:** _____

**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**

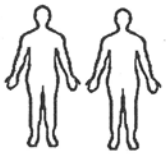
❒ Abdomen ❒ Back ❒ Leg

Other _____

_____

_____

**Front** **Back**



**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 _____

_____

_____

# 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:**

_____ _____ _____

_____ _____ _____

_____ _____ _____

**Are you on a special diet?** ❒ **Yes** ❒ **No** **(if yes, please explain)** _____

_____

_____

_____

_____

# CURRENT MEDICATION / SURGERY WORKSHEET

**Age:** _____ **Height:** _____ **Weight:** _____

**Smoke:** ☐ Yes ☐ No _____ Packs/day (X's _____ Years)

**Alcohol:** ☐ Yes ☐ No ☐ Rare ☐ Occasional ☐ Moderate

## Current Medications

| NAME | DOSE | FREQUENCY | NAME | DOSE | FREQUENCY |
|---|---|---|---|---|---|
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## Drug/Food Allergies

| NAME | TYPE REACTION |
|---|---|
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## Past Surgical History

| LIST ALL | |
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# Review of Systems

Do you now or have you had any problems related to the following systems?

**Check Yes or No**

| Constitutional Symptoms | YES | NO |
|---|---|---|
| Fever | ❒ | ❒ |
| Chills | ❒ | ❒ |
| Headache | ❒ | ❒ |
| Other _____ | | |

| Eyes | | |
|---|---|---|
| Blurred vision | ❒ | ❒ |
| Double vision | ❒ | ❒ |
| Pain | ❒ | ❒ |
| Other _____ | | |

| Allergic/Immunologic | | |
|---|---|---|
| Hay Fever | ❒ | ❒ |
| Drug allergies | ❒ | ❒ |
| Other _____ | | |

| Neurological | | |
|---|---|---|
| Tremors | ❒ | ❒ |
| Dizzy spells | ❒ | ❒ |
| Numbness/tingling | ❒ | ❒ |
| Other _____ | | |

| Endocrine | | |
|---|---|---|
| Excessive thirst | ❒ | ❒ |
| Too hot/cold | ❒ | ❒ |
| Tired/sluggish | ❒ | ❒ |
| Other _____ | | |

| Gastrointestinal | | |
|---|---|---|
| Abdominal pain | ❒ | ❒ |
| Nausea/vomiting | ❒ | ❒ |
| Indigestion/heartburn | ❒ | ❒ |
| Other _____ | | |

| Cardiovascular | | |
|---|---|---|
| Chest pain | ❒ | ❒ |
| Varicose veins | ❒ | ❒ |
| High blood pressure | ❒ | ❒ |
| Other _____ | | |

| Integumentary | YES | NO |
|---|---|---|
| Skin rash | ❒ | ❒ |
| Boils | ❒ | ❒ |
| Persistent itch | ❒ | ❒ |
| Other _____ | | |

| Musculoskeletal | | |
|---|---|---|
| Joint pain | ❒ | ❒ |
| Neck pain | ❒ | ❒ |
| Back pain | ❒ | ❒ |
| Other _____ | | |

| Ear/Nose/Throat/Mouth | | |
|---|---|---|
| Ear infection | ❒ | ❒ |
| Sore throat | ❒ | ❒ |
| Sinus problems | ❒ | ❒ |
| Other _____ | | |

| Genitourinary | | |
|---|---|---|
| Urine retention | ❒ | ❒ |
| Painful urination | ❒ | ❒ |
| Urinary frequency | ❒ | ❒ |
| Other _____ | | |

| Respiratory | | |
|---|---|---|
| Wheezing | ❒ | ❒ |
| Frequent cough | ❒ | ❒ |
| Shortness of breath | ❒ | ❒ |
| Other _____ | | |

| Hematologic/Lymphatic | | |
|---|---|---|
| Swollen glands | ❒ | ❒ |
| Blood clotting problem | ❒ | ❒ |
| Other _____ | | |

| Psychologic | | |
|---|---|---|
| Are you generally satisfied with your life? | ❒ | ❒ |
| Do you feel severely depressed? | ❒ | ❒ |
| Have you considered suicide? | ❒ | ❒ |
| Other _____ | | |