

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)

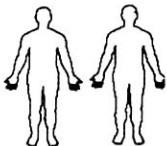
History of Present Illness

Please answer the following questions

Location of the problem

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 _____

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 _____

Are you on any medications? Do you use any herbal medicines or alternative therapies?

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)

Do you smoke? Y N

If yes, how much? _____

Do you drink? Y N

If yes, how much? _____

Specific Allergies: Have you ever had problems with:

Latex Y N Anesthesia Y N Blood Transfusion Y N
X-ray dye Y N What type of reaction did you have?

Physician use only: (Comments/Notes)

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

(OVER)