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? (Please describe your problem in detail)

_____

_____

_____

History of Present Illness

(Please answer the following questions)

Location of the problem

Abdomen Back Front

Other_____

_____

_____

Front **Back**

How long does the problem last?

30 minutes 1 Hour It is always there

Otros _____

_____

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

Is anything else occurring at the same time?

Yes **No** If yes, please explain

Nausea Rash Headaches

Other_____

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other_____

Is the problem constant or variable?

Dull then Sharp Very sharp then leaves Always there

Other_____

Does anything help or make the problem worse?

Moving around Standing up Lying on my side

Other_____

Does the problem interfere with your normal functions?

Yes **No** If yes, please explain

_____

Physician use only: (Comments/Notes)

# Anwers	Level of Service
1 - 3	1 o 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? **Yes** **No**

If yes, how much?_____

Do you drink? **Yes** **No**

If yes, how much?_____

Are you on any medication? **Yes** **No** **(If yes, list all)**

_____

_____

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

_____

Do you have allergies? **Yes** **No** **(If yes, please explain)**

_____

_____

_____

Physician use only: (Comments/Notes)

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

(Over)

Review of Systems

Are you currently having any problems related to the following systems? Please circle Yes or No.
Please explain any yes answers in the space provided.

Constitutional Symptoms
Fever Y N
Chills Y N
Headaches 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 ho/cold Y N
Tired/sluggish Y N
Other_____

Gastrointestinal
Abdominal pain Y N
Nausea/vomiting Y N
Indigestion/heartburn
Other_____

Cardiovascularlar
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_____

Psychological
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)

# Answers	Level of service
0 - 1	1 o 2
2 - 9	3
10 +	4 o 5

Physician : _____ Date: _____/_____/_____