PATIENT HISTORY FORM

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

Location of the problem
Abdomen Back Leg
Other____

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 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 AlwaysThere
Other ____

Does the problem interfere with your normal function?
Yes No If yes, please explain ______________________
____

Physician use only:

Past Medical History & Social History

List all serious illnesses and surgeries you have had in your lifetime.

List any family past illnesses and/or surgeries. (examples: diabetes,tuberculosis, breast cancer, heart disease)

Do you smoke? Yes No
If yes, how much? ________________________________
Do you drink? Yes No
If yes how much? ________________________________

Are you on any medications? Yes No (If yes, list with dosage)

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

Any allergies/medication reactions? Yes No (If yes, explain)

Physician use only: