

PATIENT HISTORY SHEET

Chart # _____

Patient Name: _____ Date of Birth: _____ Today's Date _____

Reason for today's visit? _____

Which Physician are you seeing today? _____

How long have you had this problem? _____ How often are you having this problem? _____

How severe is this problem mild moderate severe Location of problem: _____

What caused this problem? _____

Do you know of anything else that may have contributed to this problem? _____

Does any other symptoms occur with this problem? _____

<i>List ANY previous SURGERY and / or HOSPITAL stay.</i>		
<i>Surgery or Illness</i>	<i>Hospital</i>	<i>Date</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST MEDICATIONS YOU ARE CURRENTLY TAKING	LIST ALL DRUG ALLERGIES
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
	LATEX ALLERGY ___ YES ___ NO

What Pharmacy do you use? _____ Telephone # _____

Patient Social History

Marital Status: Single Married Separated Divorced Widowed Significant Other

Alcohol use: Never Rarely Moderate Daily amount per week _____ ?

Tobacco use: Never Previously, but quit. Current packs per day _____ ?

Non-prescription drug use: Never Type / Frequency _____ ?

Patient Family History

Have you or any member of your family had any of the following?

	Circle one	You?	Father, Mother, Brother or Sister?
Arthritis	no yes	_____	_____
Bleeding tendency	no yes	_____	_____
Cancer	no yes	_____	_____
Convulsions	no yes	_____	_____
Diabetes	no yes	_____	_____
Emphysema	no yes	_____	_____
Heart trouble	no yes	_____	_____
Hepatitis	no yes	_____	_____
HIV / AIDS	no yes	_____	_____
Hypertension	no yes	_____	_____
Kidney Disease	no yes	_____	_____
Liver Disease	no yes	_____	_____
Nervous Disorders	no yes	_____	_____
Pacemaker	no yes	_____	_____
Sexually Transmitted Disease	no yes	_____	_____
Stroke	no yes	_____	_____

Patient's Personal History

Have you experienced any of the following in the past year?

GENERAL		MALE	
<u>Fever</u>	No Yes	<u>Testicle pain or mass</u>	No Yes
<u>Fatigue</u>	No Yes		
<u>Headache</u>	No Yes	FEMALE	
<u>Sweats</u>	No Yes	<u>Painful periods</u>	No Yes
<u>Chills</u>	No Yes	<u>Irregular periods</u>	No Yes
<u>Weight loss</u>	No Yes	<u>Vaginal discharge</u>	No Yes
		<u># pregnancies</u>	<u># miscarriage</u>
EYES		<u>Date of last pap smear</u>	
<u>Blurred or Double Vision</u>	No Yes	<u>Results of last pap smear</u> ___ normal ___ abnormal	
ENT		MUSCULOSKELETAL	
<u>Difficulty swallowing</u>	No Yes	<u>Joint pain</u>	No Yes
<u>Hearing loss</u>	No Yes	<u>Joint stiffness or swelling</u>	No Yes
<u>Ringing in ears</u>	No Yes	<u>Weakness of muscles or joints</u>	No Yes
<u>Earache or drainage</u>	No Yes	<u>Muscle pain or cramps</u>	No Yes
<u>Sinus problems</u>	No Yes	<u>Back pain</u>	No Yes
<u>Nose bleeds</u>	No Yes		
<u>Mouth sores</u>	No Yes	SKIN	
<u>Bleeding gums</u>	No Yes	<u>Rash or itching</u>	No Yes
<u>Sore throat or voice change</u>	No Yes	<u>Change in moles</u>	No Yes
<u>Swollen neck glands</u>	No Yes	<u>Varicose Veins</u>	No Yes
CARDIOVASCULAR		<u>Breast pain</u>	No Yes
<u>Chest pain</u>	No Yes	<u>Breast lump</u>	No Yes
<u>Sudden heart beat changes</u>	No Yes	<u>Breast discharge</u>	No Yes
<u>Swelling of feet, ankles or hands</u>	No Yes	NEUROLOGICAL	
RESPIRATORY		<u>Frequent or recurring headaches</u>	No Yes
<u>Frequent coughing</u>	No Yes	<u>Light headed or dizzy</u>	No Yes
<u>Spitting up blood</u>	No Yes	<u>Convulsions or seizures</u>	No Yes
<u>Shortness of breath</u>	No Yes	<u>Numbness or tingling sensation</u>	No Yes
<u>Asthma or wheezing</u>	No Yes	<u>Tremors</u>	No Yes
		<u>Paralysis</u>	No Yes
		<u>Stroke</u>	No Yes
GASTROINTESTINAL		PSYCHIATRIC	
<u>Loss of appetite</u>	No Yes	<u>Memory loss or confusion</u>	No Yes
<u>Change in bowel movements</u>	No Yes	<u>Nervousness</u>	No Yes
<u>Nausea or vomiting</u>	No Yes	<u>Depression</u>	No Yes
<u>Frequent diarrhea</u>	No Yes	<u>Sleep problems</u>	No Yes
<u>Painful bowel movements</u>	No Yes		
<u>Constipation</u>	No Yes	ENDOCRINE	
<u>Blood in stool</u>	No Yes	<u>Glandular or hormone problems</u>	No Yes
<u>Rectal bleeding</u>	No Yes	<u>Thyroid disease</u>	No Yes
<u>Hemorrhoids</u>	No Yes	<u>Excessive thirst or urination</u>	No Yes
<u>Bloating</u>	No Yes	<u>Heat or cold intolerance</u>	No Yes
<u>Stomach pain</u>	No Yes	<u>Dry skin</u>	No Yes
<u>Indigestion</u>	No Yes		
GENITOURINARY		HEMATOLOGIC / LYMPHATIC	
<u>Frequent urination</u>	No Yes	<u>Slow to heal after cuts</u>	No Yes
<u>Burning or painful urination</u>	No Yes	<u>Easily bruised or bleed</u>	No Yes
<u>Blood in urine</u>	No Yes	<u>Anemia</u>	No Yes
<u>Change of force/strain when urinating</u>	No Yes	<u>Phlebitis</u>	No Yes
<u>Incontinence or dribbling</u>	No Yes	<u>Past blood transfusion</u>	No Yes
<u>Kidney stones</u>	No Yes	<u>Enlarged glands</u>	No Yes
		<u>Taking any Blood Thinners</u>	No Yes

I have confirmed the above information to be correct.

Patient Signature: _____ **Today's Date:** _____

If this history was filled out by other than patient. Print name and relationship. _____

I have reviewed this patient history infor **Physician Signature:** _____