

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.

Today's Date _____ / _____ / _____

Date of Last Physical Exam _____ / _____ / _____

Last Name _____ **First** _____ **Middle** _____

Social Security Number _____ - _____ - _____ **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 _____

How long does the problem last?

30 minutes **1 hour** **It is always there**

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 _____

Is anything else occurring at the same time?

Nausea **Rash** **Headaches**

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** **Laying on my side**

Other _____

Does the problem interfere with your normal functions?

YES **NO**

If yes, please explain _____

Physician use only: (Comments / Notes)

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

PAST MEDICAL & SOCIAL HISTORY

List all serious illnesses in your 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?

YES **NO**

If yes, List them all _____

Do you Smoke?

YES **NO**

If yes, how much? _____

Are you on a special diet?

YES **NO**

If yes, explain _____

Do you Drink?

YES **NO**

If yes, how much? _____

Do you have allergies?

YES **NO**

If yes, explain _____

Physician use only: (Comments/ Notes)

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

