# 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 ☐***

***Is anything else occurring at the same time?***
***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 ☐ Laying on my side ☐***
***Other_____***

***Does the problem interfere with your normal functions?***
***YES ☐ NO ☐***
***If yes, please explain_____***

***Physician use only: (Comments / Notes)***

____ Year old male requesting a vasectomy for male sterilization,

The patient has_____children

| # 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)***

PMH:

PSH:

MEDS:

Social: Married ( ) ETOH use ( )

Tobacco use
Seat belts
Illegal drug use

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