

Comprehensive Patient History Form

Patient Name: _____ DOB: _____ Age: _____ Date: _____

Primary Care Physician _____ Who referred you to this office today? _____

Describe your main problem _____

Where is your problem located? _____

How severe is your problem? _____

How long have you had this problem? _____

When does this problem occur? _____

Where were you when this problem started? _____

What other things happen with this problem? _____

List previous hospitalizations/Surgeries/Serious Injuries	When?
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Patient Social History

Marital Status: Single Married Separated Divorced Widowed

Use of alcohol: Never Rarely Moderate Daily _____

Use of tobacco: Never Previously but quit Current Packs per day _____

Use of Drugs: Never Type/Frequency _____

Excessive exposure at home or work to: Fumes Dust Solvents Noise

Family History

If your father, mother, sister(s), or brother(s) have a history of any of the following please indicate the disease or condition by placing a √ in the box.

Type of Cancer: Breast Colon Ovarian
 Lung Skin Pancreas
 Stomach Bladder
 Other _____

Diabetes High Blood Pressure Heart Trouble

Tuberculosis Other _____

Has a surgeon in this group ever seen a member of your family?

Yes No

Have you ever had the following?		
Diabetes.....	yes	no
Hypertension.....	yes	no
Cancer.....	yes	no
Stroke.....	yes	no
Heart trouble.....	yes	no
Arthritis/gout.....	yes	no
Convulsions.....	yes	no
Bleeding tendency.....	yes	no
Acute infections.....	yes	no
Venereal disease.....	yes	no
Hereditary defects.....	yes	no
Implanted parts	yes	no

List Medications you are currently taking (list doses and frequency)
1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____

ALLERGIC/IMMUNOLOGIC
List allergies to any medications, especially antibiotics, pain killers, anesthetics, or antiseptics.

Other drugs/medications

<input type="checkbox"/> No known drug allergies
Known food allergies

PLEASE ANSWER ALL QUESTIONS

For items containing "or" please circle all conditions that apply.

Have you had any of the following during the past three months?

Name: _____

Date: _____

CONSTITUTIONAL

Recent weight loss No Yes
 Recent weight gain No Yes
 Fever No Yes
 Fatigue No Yes
 Chills No Yes
 Night sweats No Yes

EYES

Eye disease or injury No Yes
 Blurred or double vision No Yes
 Sudden change in vision No Yes

ENT

Hearing loss No Yes
 Ringing in the ears No Yes
 Earaches or drainage No Yes
 Sinus problems No Yes
 Nose bleeds No Yes
 Mouth sores No Yes
 Bleeding gums No Yes
 Bad breath or bad taste No Yes
 Sore throat or voice change (hoarseness) No Yes
 Swollen glands in neck No Yes

CARDIOVASCULAR

Heart trouble No Yes
 Chest pains No Yes
 Sudden heart beat changes No Yes
 Swelling of feet, ankles or hands No Yes
 Swelling of feet, ankles or hands while lying flat No Yes

RESPIRATORY

Frequent coughing No Yes
 Spitting up blood No Yes
 Shortness of breath No Yes
 Asthma or wheezing No Yes

GASTROINTESTINAL

Loss of appetite No Yes
 Change in bowel movements No Yes
 Nausea or vomiting No Yes
 Frequent diarrhea No Yes
 Painful bowel movements or constipation No Yes
 Red blood in stool No Yes
 Stomach pain No Yes
 Black tarry bowel movements No Yes
 Clay (light) colored stool No Yes
 Food intolerance No Yes
 Difficulty swallowing No Yes
 Yellow jaundice No Yes
 Heartburn No Yes

GENTOURINARY

Frequent urination No Yes
 Burning with urination No Yes
 Painful urination No Yes
 Blood in urine No Yes
 Change of force or strain when urinating No Yes
 Incontinence or dribbling No Yes
 Sexual difficulty No Yes
 Male – testicle pain No Yes
 Female – pain with periods No Yes
 Female – irregular periods No Yes
 Female – vaginal discharge No Yes
 Female – # pregnancies _____ # miscarriages _____

MUSCULOSKELETAL

Joint pain No Yes
 Joint stiffness or swelling No Yes
 Weakness of muscles or joints No Yes
 Muscle pain or cramps No Yes
 Back pain No Yes
 Cold extremities No Yes
 Difficulty in walking No Yes

SKIN

Rash or itching No Yes
 Change in hair or nails No Yes
 Varicose veins No Yes
 Breast pain No Yes
 Breast lump No Yes
 Breast discharge No Yes

NEUROLOGICAL

Frequent or recurring headaches No Yes
 Light headed or dizzy No Yes
 Numbness or tingling sensations No Yes
 Paralysis No Yes

PSYCHIATRIC

Memory loss or confusion No Yes
 Nervousness No Yes
 Depression No Yes
 Sleep problems No Yes

ENDOCRINE

Grandular or hormone problem No Yes
 Excessive thirst or urination No Yes
 Heat or cold intolerance No Yes

HEMATOLOGIC/LYMPHATIC

Easily bruise or bleed No Yes
 Anemia No Yes
 Blood clots No Yes
 Past transfusion No Yes
 Enlarged glands No Yes

Reviewed and updated:

MD Initials _____ Date _____

MD Initials _____ Date _____

MD Initials _____ Date _____

Patient Signature: _____

Physician Signature: _____

Where do you go for lab work? _____

Which pharmacy do you typically use? _____

Where do you go for x-rays? _____

Have you had lab work within the past 3 months? Yes No

Have you had an EKG or chest x-ray within the past 6 months? Yes No