ALL PEOPLE'S HEALTH CENTER, 8065 webb Ave Suite A, North Hollywood, CA 91605

Comprehensive Patient History Form

Patient Name:_____ DOB:_____ Today's Date: _____

Describe your main problem _____

Where is your problem located?_____

How severe is your problem? _____

Rate the severity of the problem: Mild > 0 1 2 3 4 5 6 7 8 9 < Severe

How long have you had this problem?_____

When does this problem occur?_____

Can you attribute the cause of this problem to anything? _____

_____

Are there other symptoms associated with the problem? _____

_____

_____

What makes this problem worse or better? _____

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
STD's…….	yes	no
Hereditary defects……..	yes	no

List previous hospitalizations/Surgeries/Serious Injuries — When?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

What Medications are you taking?

N/A

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

8)_____

9)_____

10)_____

11)_____

12) _____

Patient Social History ❑ Noncontributory

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Use of alcohol: ❑ Never ❑ Rarely ❑ Socially ❑ Daily _____

Use of tobacco: ❑ Never ❑ Previously quit ❑ Current packs per day _____

Use of Drugs: ❑ Never ❑ Type/Frequency_____

Excessive exposure at home or work to: ❑ Fumes ❑ Dust ❑ Solvents ❑ Noise ❑ Chemicals ❑ Smoke ❑ Animal Hair

Family Medical History ❑ Noncontributory

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

PLEASE ANSWER ALL QUESTIONS

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

CONSTITUTIONAL

Good general health lately……..	No	Yes
Recent weight change…….	No	Yes
Fever……...	No	Yes
Fatigue……	No	Yes
Headaches……...	No	Yes

EYES

Eye disease or injury……..	No	Yes
Wear glasses/contact lens……..	No	Yes
Blurred or double vision……	No	Yes
Glaucoma……...	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…….	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

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
Blood in stool……..	No	Yes
Stomach pain……	No	Yes

GENITOURINARY

Frequent urination……	No	Yes
Burning or painful urination……	No	Yes
Blood in urine……..	No	Yes
Change of force of strain when urinating……	No	Yes
Incontinence or dribbling…….	No	Yes
Kidney stones……..	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 _____

Female – date of last pap smear _____

Female – findings of last pap smear ❑ Normal ❑ Abnormal

Date: _____

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 skin color……	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
Convulsions or seizures……	No	Yes
Numbness or tingling sensations……..	No	Yes
Tremors……	No	Yes
Paralysis……...	No	Yes
Stroke……	No	Yes
Head injury……	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
Thyroid disease……	No	Yes
Diabetes……	No	Yes
Excessive thirst or urination……	No	Yes
Heat or cold intolerance……..	No	Yes
Dry skin……...	No	Yes
Change in hat or glove size…….	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts…….	No	Yes
Easily bruise or bleed……..	No	Yes
Anemia…….	No	Yes
Phlebitis……	No	Yes
Past transfusion……	No	Yes
Enlarged glands……	No	Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reactions to:

Penicillin or other antibiotics……	No	Yes
Morphine, Demerol or other narcotics..	No	Yes
Novocaine or other anesthetics…….	No	Yes
Aspirin or other pain remedies…….	No	Yes
Tetanus antitoxin or other serums……	No	Yes
Iodine, methiolate or other antiseptic…	No	Yes

Other drugs/medications _____

_____

Known food allergies _____

Patient Signature: _____

Physician Signature: _____