

**Comprehensive Patient History Form**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Describe your main problem \_\_\_\_\_

<p>Where is your problem located? _____</p> <p>How severe is your problem? _____</p> <p>Rate the severity of the problem: Mild &gt; 0 1 2 3 4 5 6 7 8 9 &lt; Severe</p> <p>How long have you had this problem? _____</p> <p>When does this problem occur? _____</p> <p>Can you attribute the cause of this problem to anything? _____</p> <p>_____</p> <p>Are there other symptoms associated with the problem? _____</p> <p>_____</p> <p>_____</p> <p>What makes this problem worse or better? _____</p>	<p style="text-align: center;"><b>Have you ever had the following?</b></p> <p>Diabetes..... yes no</p> <p>Hypertension..... yes no</p> <p>Cancer..... yes no</p> <p>Stroke..... yes no</p> <p>Heart trouble..... yes no</p> <p>Arthritis/gout..... yes no</p> <p>Convulsions..... yes no</p> <p>Bleeding tendency..... yes no</p> <p>Acute infections..... yes no</p> <p>Venereal disease..... yes no</p> <p>STD's..... yes no</p> <p>Hereditary defects..... yes no</p>
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<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; border-bottom: 1px solid black;">List previous hospitalizations/Surgeries/Serious Injuries</td> <td style="width: 40%; border-bottom: 1px solid black;">When?</td> </tr> <tr> <td style="border-bottom: 1px solid black;">_____</td> <td style="border-bottom: 1px solid black;">_____</td> </tr> <tr> <td style="border-bottom: 1px solid black;">_____</td> <td style="border-bottom: 1px solid black;">_____</td> </tr> <tr> <td style="border-bottom: 1px solid black;">_____</td> <td style="border-bottom: 1px solid black;">_____</td> </tr> <tr> <td style="border-bottom: 1px solid black;">_____</td> <td style="border-bottom: 1px solid black;">_____</td> </tr> </table>	List previous hospitalizations/Surgeries/Serious Injuries	When?	_____	_____	_____	_____	_____	_____	_____	_____	<p><b>What Medications are you taking?</b></p> <p>N/A</p> <p>1) _____</p> <p>2) _____</p> <p>3) _____</p> <p>4) _____</p> <p>5) _____</p> <p>6) _____</p> <p>7) _____</p> <p>8) _____</p> <p>9) _____</p> <p>10) _____</p> <p>11) _____</p> <p>12) _____</p>
List previous hospitalizations/Surgeries/Serious Injuries	When?										
_____	_____										
_____	_____										
_____	_____										
_____	_____										

<p>Patient Social History      <input type="checkbox"/> Noncontributory</p> <p>Marital Status:    <input type="checkbox"/> Single    <input type="checkbox"/> Married    <input type="checkbox"/> Separated    <input type="checkbox"/> Divorced    <input type="checkbox"/> Widowed</p> <p>Use of alcohol:    <input type="checkbox"/> Never    <input type="checkbox"/> Rarely    <input type="checkbox"/> Socially    <input type="checkbox"/> Daily _____</p> <p>Use of tobacco:    <input type="checkbox"/> Never    <input type="checkbox"/> Previously quit    <input type="checkbox"/> Current packs per day _____</p> <p>Use of Drugs:      <input type="checkbox"/> Never    <input type="checkbox"/> Type/Frequency _____</p> <p>Excessive exposure at home or work to: <input type="checkbox"/> Fumes    <input type="checkbox"/> Dust    <input type="checkbox"/> Solvents    <input type="checkbox"/> Noise</p> <p style="text-align: center;"><input type="checkbox"/> Chemicals    <input type="checkbox"/> Smoke    <input type="checkbox"/> Animal Hair</p>	
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Family Medical History	<input type="checkbox"/> Noncontributory	<u>Diseases</u>	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?*

<b>CONSTITUTIONAL</b>		
Good general health lately.....	No	Yes
Recent weight change.....	No	Yes
Fever.....	No	Yes
Fatigue.....	No	Yes
Headaches.....	No	Yes
<b>EYES</b>		
Eye disease or injury.....	No	Yes
Wear glasses/contact lens.....	No	Yes
Blurred or double vision.....	No	Yes
Glaucoma.....	No	Yes
<b>ENT</b>		
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
<b>CARDIOVASCULAR</b>		
Heart trouble.....	No	Yes
Chest pains.....	No	Yes
Sudden heart beat changes.....	No	Yes
Swelling of feet, ankles or hands.....	No	Yes
<b>RESPIRATORY</b>		
Frequent coughing.....	No	Yes
Spitting up blood.....	No	Yes
Shortness of breath.....	No	Yes
Asthma or wheezing.....	No	Yes
<b>GASTROINTESTINAL</b>		
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
<b>GENITOURINARY</b>		
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 <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
Date: _____		

<b>MUSCULOSKELETAL</b>		
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
<b>SKIN</b>		
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
<b>NEUROLOGICAL</b>		
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
<b>PSYCHIATRIC</b>		
Memory loss or confusion.....	No	Yes
Nervousness.....	No	Yes
Depression.....	No	Yes
Sleep problems.....	No	Yes
<b>ENDOCRINE</b>		
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
<b>HEMATOLOGIC/LYMPHATIC</b>		
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
<b>ALLERGIC/IMMUNOLOGIC</b>		
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: \_\_\_\_\_