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 to do so.

TODAY'S DATE _______/______/______ **DATE OF LAST PHYSICAL EXAM** _____/______/______

LAST NAME ________________________ **FIRST NAME** _______________ **MIDDLE** ___________

SOCIAL SECURITY NO. _______________ **DATE OF BIRTH** /______/______

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

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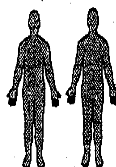
History of Present Illness

Please answer the following questions

Location of the problem **Front** **Back**



Abdomen Back Leg

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 ______________________________

Does anything help or make the problem worse?

Moving around Standing up Lying on my side

Other ______________________________

How long does the problem last?

30 minutes I hour It is always there

Other ______________________________

Is anything else occurring at the same time?

YES **NO** If yes, please explain.

Nausea Rash Headaches

Other ______________________________

Is the problem constant or variable?

Dull then sharp Very sharp then leaves Always there

Other ______________________________

Does the problem interfere with your normal functions?

YES **NO** If yes, please explain _______

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Past Medical & Social History

List all serious illnesses in your immediate 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
____________	________
____________	________
____________	________
____________	________

Do you smoke? Y N

If yes, how much? ______________

Do you drink? Y N

If yes, how much? ______________

Are you on any medications? Y N (If yes, list all.)

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

Do you have allergies? Y N (If yes, please explain.)

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(OVER)