# PATIENT HISTORY

Patient Name: Height: Weight: Today's Date: Age: Date of Birth: \_\_\_

 Name of Primary Care/Family Physician: **CHIEF COMPLAINT**

Why are you seeing the doctor today?

Have you been treated for this problem? ( ) No ( ) Yes

Date of injury / Onset of problem: Current problem is the result of a(n): CHECK all that apply

Car Accident Work Accident Other Accident State accident occurred in:

**PAST MEDICAL HISTORY** *(are you currently receiving treatment or have you received treatment in the past for any of the following conditions?)*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Yes | No | Yes | No | Yes | No |  | Yes | No |
|   |  Anemia |   |   | Diabetes  |   | Low Blood Pressure |   |  Sexually Trans- |
|   |  Arthritis |   |   | Epilepsy  |   | Lung Problems |  | mitted Disease |
|   |  Asthma |   |   | Heart Disease  |   | Phelbitis/Blood Clots |   |  Stroke |
|   |  Birth Defects |   |   | Hepatitis  |   | Polio |   |  TB |
|   |  Bladder Problems |   |   | HIV  |   | Psychological |   |  Thyroid Diease |
|   |  Bleeding Disorder |   |   | High Blood Pressure  |   | Recurrent Infection |   |  Ulcer |
|   |  Bowel Problem(s) |   |   | Kidney Disease  |   | Rheumatic Fever |   |  Currently Pregnant |
|   |  Cancer |   |   | Intestinal Disorder  |   | Scarlet Fever |  |  |

Please specify any other medical problems:

**DRUG ALLERGIES:** *Please describe any drug symptom(s) you have, listing your common reaction and treatment for this problem*

|  |  |  |
| --- | --- | --- |
| Allergy To (drug name) | Reaction (itching, cough, hives, etc) | How is/was reaction treated: |
|  |  |  |
|  |  |  |
|  |  |  |

( ) I do NOT have any known drug allergies

# SURGICAL HISTORY:

|  |  |  |
| --- | --- | --- |
| Surgery/Hospitalizations | Year | Any complications |
|  |  |  |
|  |  |  |
|  |  |  |

Have you ever had any problem with anesthesia? ( ) No ( ) Yes - describe:

***Over please***

**FAMILY HISTORY:** *(Have mother, father, grandparents, brothers or sisters been treated in the past or are currently receiving treatment for any of the following conditions?)*

 Cancer Diabetes Heart Disease Tuberculosis Kidney Disease Arthritis

 None of these Other (specify)

# PLEASE LIST HEALTH STATUS OR CAUSE OF DEATH FOR THE FOLLOWING FAMILY MEMBERS:

Mother: Father:

# SOCIAL HISTORY

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

( ) Employed - occupation ( ) Work in home ( ) Student ( ) Retired Children? ( ) No ( ) Yes - # Do you live alone? ( ) No ( ) Yes

Smoking currently? ( ) No ( ) Yes # packs per day for years.

Do you consume alcohol products? ( ) No ( ) Yes if yes, amount and frequency

**REVIEW OF SYSTEMS:** *Please mark the following symptoms you have experienced on a regular basis*

GENERAL

EYES

THROAT

GASTROINTESTINAL

 fever

 night sweats

 weight gain

blurring

eyestrain

glasses/contacts

soreness

hoarsness

difficulty swallowing

nausea vomiting belching

 weight loss

discharge

diarrhea

SKIN

EARS

GENITOURINARY

NEUROMUSCULAR

eruptions/rashes

 cyanosis (bluish tint)

jaundice (yellow tint)

deafness

ringing in ears

pain

pain

frequent urination

incontinence

fever

night sweats weight gain

 discharge weight loss

HEAD

NOSE

CARDIOVASCULAR

RESPIRATORY

 headache

 fainting/blackouts

sinusitis

obstruction

chest pain

rapid/throbbing heartbeat

chest pain difficulty breathing

 trauma

faintness

bloody sputum

 fluid/swelling in extremities Date of last chest x-ray

**MEDICATIONS:** *Please list all medications you take* ***with or without a prescription*** *(use additional paper if needed)*

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name | Dosage / # per day | Reason you take this | Any side effects |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to provide any change in my medical history to my doctor.

Patient Signature: Date: