



PATIENT HISTORY FORM

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 _____ / _____ / _____

Last Name _____ First Name _____ M.I. _____

Social Security No. _____ Date of Birth _____ / _____ / _____

Family, Primary Care and/or Referring Physician _____

What is the reason for your visit today? _____

When did your symptoms begin? _____

Have you already started treatment? YES NO

If YES,

what type of treatment? _____

where did you receive treatment? _____

Have you had any of the following studies? X-rays MRI Other _____

Where did you have your study? _____

List any ALLERGIES you have:

List any MEDICATIONS you take:

List any previous significant TRAUMA:

Indicate any SURGERIES you have had and the DATE(s):

How tall are you? _____ What do you weight? _____

Do YOU have any of the following medical problems?

<input type="checkbox"/> AIDS	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma or Lung	<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Other _____		

Do you smoke? YES NO If YES, how many packs per day? _____ for _____ years

Do you drink alcohol? YES NO If YES, how many drinks per week? _____
What types? Beer Wine Liquor

Do you take drugs not prescribed by a doctor? YES NO

Do any of the following medical problems run in your FAMILY? If yes, WHO? (mother, brother, etc.)

<input type="checkbox"/> Arthritis, who _____	<input type="checkbox"/> Asthma or Lung, who _____	<input type="checkbox"/> Cancer, who _____
<input type="checkbox"/> Diabetes, who _____	<input type="checkbox"/> Heart, who _____	<input type="checkbox"/> Stroke, who _____
<input type="checkbox"/> Thyroid, who _____	<input type="checkbox"/> High Blood Pressure, who _____	
<input type="checkbox"/> Other _____		_____ , who _____

(OVER)

REVIEW OF SYSTEMS

Do you **now** or **have you had within the past 6 months** any problems related to the following systems?
Circle Yes or No.

Please explain any Yes answers in space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other _____		

Allergic / Immunologic

Hay Fever	Y	N
Drug allergies	Y	N
Other _____		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other _____		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other _____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other _____		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure?	Y	N
Other _____		

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other _____		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other _____		

Ear / Nose / Throat / Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other _____		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other _____		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other _____		

Hematologic / Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other _____		

Psychologic

Anxiety	Y	N
Depression	Y	N
Suicidal thoughts	Y	N
Other _____		

Physician/Office use only: (Comments/Notes)

Physician: _____ Date: _____