

**PATIENT HISTORY**

Patient Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Who Referred You: \_\_\_\_\_

Name of Primary Care/Family Physician: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

**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 Transmitted Disease
___	___	Arthritis	___	___	Epilepsy	___	___	Lung Problems	___	___	Stroke
___	___	Asthma	___	___	Heart Disease	___	___	Phelbitis/Blood Clots	___	___	TB
___	___	Birth Defects	___	___	Hepatitis	___	___	Polio	___	___	Thyroid Disease
___	___	Bladder Problems	___	___	HIV	___	___	Psychological	___	___	Ulcer
___	___	Bleeding Disorder	___	___	High Blood Pressure	___	___	Recurrent Infection	___	___	Currently Pregnant
___	___	Bowel Problem(s)	___	___	Kidney Disease	___	___	Rheumatic Fever	___	___	
___	___	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: \_\_\_\_\_

Reviewed by \_\_\_\_\_

*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**

fever  
 night sweats  
 weight gain  
 weight loss

**EYES**

blurring  
 eyestrain  
 glasses/contacts  
 discharge

**THROAT**

soreness  
 hoarseness  
 difficulty swallowing

**GASTROINTESTINAL**

nausea  
 vomiting  
 belching  
 diarrhea

**SKIN**

eruptions/rashes  
 cyanosis (bluish tint)  
 jaundice (yellow tint)

**EARS**

deafness  
 ringing in ears  
 pain  
 discharge

**GENITOURINARY**

pain  
 frequent urination  
 incontinence

**NEUROMUSCULAR**

fever  
 night sweats  
 weight gain  
 weight loss

**HEAD**

headache  
 fainting/blackouts  
 trauma

**NOSE**

sinusitis  
 obstruction

**CARDIOVASCULAR**

chest pain  
 rapid/throbbing heartbeat  
 faintness  
 fluid/swelling in extremities

**RESPIRATORY**

chest pain  
 difficulty breathing  
 bloody sputum  
Date of last chest x-ray \_\_\_\_\_

**FEMALE REPRODUCTIVE:**

Are you or could you be pregnant? ( ) No    ( ) Yes

**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

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_, M.D. Date: \_\_\_\_\_

Annual update (to be completed after one year): There are NO CHANGES to the above information in my medical history.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_