

PATIENT HISTORY

SIDE 1

Name: _____ Chart Number: _____

Date _____ Social Security # _____ Age _____ M / F

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Current problem is the result of: *(Check all that apply)*

- A Car Accident A Work Accident An Accident Other _____

Date of Injury/Onset _____

Were X-Rays taken? Yes No MRI? Yes No

This occurred as a result of: *(Check all that apply)*

- Lifting Pulling Pushing Twisting Falling Bending Reaching Squatting
 Hit by object Not Known

MEDICATION	DOSE	HOW OFTEN?	MEDICATION	DOSE	HOW OFTEN?

Do you have any allergies? No Yes If yes, please list allergy and reaction:

- 1 _____ 4 _____
2 _____ 5 _____
3 _____ 6 _____

REVIEW OF SYSTEMS *(please check all that apply)*

Constitutional

- Fever
 Chills
 Weight loss
 Night sweats

Eyes

- Blurred vision
 Blindness
 One or Both

Ears/Nose/Throat

- Sinusitis
 Sore throat
 Hoarseness
 Hearing loss
 Difficulty swallowing

Cardiovascular

- Heart attack
 High blood pressure
 Chest pain

Respiratory

- Shortness of breath
 Chronic cough
 Productive cough
 Emphysema
 Asthma
 Coughing blood
 Tuberculosis

Gastrointestinal

- Nausea
 Vomiting
 Constipation
 Diarrhea
 Blood in stool
 Vomiting blood
 Chronic heartburn
 Blackberry stool
 Clay colored stool
 Hemorrhoids
 Colorectal polyps
 Ulcers
 Crohn's disease
 Colitis
 Irritable bowel
 Weight gain
 Hepatitis

Genitourinary

- Nighttime voiding
 Blood in urine
 Change in urine color
 Urine stream change
 Prostate disease
 Change in urine

Skin

- Allergies
 Skin rashes
 Moles

Breast

- Breast lumps
 Breast pain
 Nipple discharge

Neurologic

- Chronic headaches
 Dizziness
 Stroke
 Paralysis
 Muscle weakness

Psychiatric

- Depression
 Schizophrenia
 Nervousness
 Shakiness
 Other psychiatric illness

Endocrine

- Diabetes
 Heat intolerance
 Excessive thirst
 Thyroid disease

Hematological

- Bleeding disorder
 Bruise easily
 Sickle cell anemia

Immune

- HIV
 AIDS

Other

- Circulation problems
 Arthritis
 Cancer

Name _____ **PAST MEDICAL HISTORY** Today's Date _____

SURGERIES/HOSPITALIZATIONS	MO/YR	COMPLICATIONS

Have you ever had general anesthesia? Yes No

For Women:

Have you any problems with anesthesia? Yes No

Is there a possibility of Pregnancy? Yes No

If yes, describe: _____

Are you post menopausal? Yes No

Date of last tetanus shot? _____

Last menstrual period _____

FAMILY HISTORY	MOTHER	FATHER	SISTER	BROTHER
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITUS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY

Work Status: Work in the home Employed (occupation _____) student

Marital Status: Single Married Divorced Separated Widowed

Do you have children: No Yes # _____

Do you live alone? No Yes

How often do you exercise? Daily Weekly Monthly Rarely Never

What type of exercise? _____

Are you on a special diet? No Yes Describe _____

Do you have a history of substance abuse? No Yes If yes, what? _____

Do you currently smoke? No Yes Packs per day for _____ years.

If you quit smoking, how long has it been? This year >1 year >5 years >10 years

Previously smoked _____ Packs per day for _____ years.

Do you drink alcohol? Daily 1-2 x/week 1-2 x/month 1-2 x/year Never

Recreational Drug use? No Yes If yes, what? _____

Reviewed By: _____ MD Date: _____