

PATIENT HISTORY FORM

FIRST NAME: _____ MI: _____ LAST NAME: _____ DATE _____

REFERRING PHYSICIAN: _____

REASON FOR VISIT: _____ LIST ALL SYMPTOMS: _____

IF SYMPTOMS INCLUDE PAIN – PLEASE CIRCLE ALL THAT APPLY: MILD MODERATE SHARP DULL STABBING CONTINUOUS INTERMITTENT SUDDEN

LOCATION OF PAIN: _____

IF ABDOMINAL PAIN – PLEASE SPECIFY LOCATION: RT UPPER RT LOWER LT UPPER LT LOWER MIDDLE OTHER: _____

WHEN DID SYMPTOM(S) OCCUR: _____ FREQUENCY OF SYMPTOM(S): _____

WHAT BRINGS SYMPTOM(S) ON?: _____ WHAT MAKES SYMPTOM(S) WORSE?: _____

PREVIOUS TESTING OR TREATMENTS FOR THIS PROBLEM: _____

MEDICATIONS: _____

ALLERGIES: _____

PERSONAL MEDICAL HISTORY

CURRENT MEDICAL PROBLEMS (CHECK IF APPLICABLE):

<input type="checkbox"/> ASTHMA	<input type="checkbox"/> ATRIAL FIBRILLATION	<input type="checkbox"/> ANXIETY/DEPRESSION
<input type="checkbox"/> CHRONIC BRONCHITIS/EMPHYSEMA	<input type="checkbox"/> CONGESTIVE HEART FAILURE	<input type="checkbox"/> CORONARY ARTERY DISEASE/ANGINA
<input type="checkbox"/> DIABETES	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> HIGH CHOLESTEROL/TRIGLYCERIDES
<input type="checkbox"/> KIDNEY FAILURE	<input type="checkbox"/> OSTEOPOROSIS/OSTEOPENIA	<input type="checkbox"/> SLEEP APNEA
<input type="checkbox"/> THYROID PROBLEMS	<input type="checkbox"/> OTHER: _____	

SURGERY (CHECK IF APPLICABLE):

<input type="checkbox"/> APPENDECTOMY	<input type="checkbox"/> GALLBLADDER	<input type="checkbox"/> HERNIA REPAIR	<input type="checkbox"/> STOMACH/DUODENAL ULCER
<input type="checkbox"/> HYSTERECTOMY/OVARIES	<input type="checkbox"/> INTESTINAL/ABDOMINAL	<input type="checkbox"/> OTHER: _____	

SOCIAL HISTORY

TOBACCO	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> QUIT (WHEN _____)	_____ PACKS PER DAY	FOR _____ YEARS
ALCOHOL	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> QUIT (WHEN _____)	_____ DRINKS PER WEEK	FOR _____ YEARS
RECREATIONAL DRUGS	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> QUIT (WHEN _____)	DRUGS USED: _____	

FAMILY HISTORY

	<u>FATHER</u>	<u>MOTHER</u>	<u>BROTHER/SISTER</u>	<u>OTHER</u>
COLON CANCER	_____	_____	_____	_____
COLON POLYP	_____	_____	_____	_____
UTERINE/OVARIAN CANCER	_____	_____	_____	_____
STOMACH/SMALL BOWEL CANCER	_____	_____	_____	_____
RENAL/URETERAL CANCER	_____	_____	_____	_____
BREAST CANCER	_____	_____	_____	_____
LIVER DISEASE/HEMOCHROMATOSIS	_____	_____	_____	_____
GALLBLADDER DISEASE	_____	_____	_____	_____
COLITIS/CROHN'S DISEASE	_____	_____	_____	_____
HEART DISEASE	_____	_____	_____	_____

REVIEW OF SYSTEMS (CHECK IF YOU HAVE ANY OF THE FOLLOWING)

<p>CONSTITUTIONAL SYMPTOMS</p> <p>___ DECREASED APPETITE</p> <p>___ UNEXPECTED WEIGHT LOSS</p> <p>___ UNEXPECTED WEIGHT GAIN</p> <p>___ FATIGUE</p> <p>___ WEAKNESS</p> <p>___ FEVER OR CHILLS</p> <p>___ NIGHT SWEATS</p> <p>___ FAINTING</p> <p>___ OTHER _____</p> <p>_____</p>	<p>INTEGUMENTARY (SKIN)</p> <p>___ RASH</p> <p>___ ITCHING</p> <p>___ SORES</p> <p>___ DRYNESS</p> <p>___ UNUSUAL HAIR LOSS</p> <p>___ OTHER _____</p> <p>_____</p> <p>_____</p>	<p>THROAT</p> <p>___ SORE THROAT</p> <p>___ HOARSENESS</p> <p>___ HARD TO SWALLOW</p> <p>___ RECURRENT INFECTION</p> <p>___ OTHER _____</p> <p>_____</p> <p>_____</p>	<p>EYES</p> <p>___ BLURRED VISION</p> <p>___ GLAUCOMA</p> <p>___ REDNESS</p> <p>___ ITCHING</p> <p>___ BURNING</p> <p>___ SWELLING</p> <p>___ PAIN</p> <p>___ DRYNESS</p> <p>___ CATARACTS</p> <p>___ DISCHARGE</p>
<p>NEUROLOGICAL</p> <p>___ HEADACHES</p> <p>___ STROKES</p> <p>___ SEIZURES</p> <p>___ OTHER _____</p> <p>_____</p> <p>_____</p>	<p>ENDOCRINE</p> <p>___ DIABETES</p> <p>___ HYPOGLYCEMIA</p> <p>___ OSTEOPOROSIS</p> <p>___ HEAT INTOLERANCE</p> <p>___ THYROID DISEASE</p>	<p>NECK</p> <p>___ ENLARGEMENT</p> <p>___ LUMPS</p> <p>___ MASSES</p> <p>___ STIFFNESS</p> <p>___ OTHER _____</p> <p>_____</p>	<p>HEMATOLOGIC (BLOOD)</p> <p>___ ANEMIA</p> <p>___ BRUISE EASILY</p> <p>___ BLOOD TRANS.</p> <p>___ RED DOTS/SPOTS</p> <p>___ OTHER _____</p> <p>_____</p>
<p>GASTROINTESTINAL</p> <p>___ ABDOMINAL PAIN ___ IRREGULAR BOWELS</p> <p>___ NAUSEA ___ CONSTIPATION</p> <p>___ VOMITING ___ DIARRHEA</p> <p>___ BLOATED ___ GERD</p> <p>___ BELCHING ___ RECTAL PAIN</p> <p>___ HEARTBURN ___ GAS</p> <p>___ INDIGESTION ___ HEMORRHOIDS</p> <p>___ HERNIAS ___ POOR APPETITE</p> <p>___ RECTAL BLEEDING ___ BLOODY STOOLS</p> <p>___ DYSPHAGIA</p> <p>___ CHANGE IN BOWEL HABITS</p> <p>___ OTHER _____</p> <p>_____</p>		<p>GENITOURINARY</p> <p>___ RENAL FAILURE/INSUFFICIENCY</p> <p>___ KIDNEY STONES</p> <p>___ DIFFICULTY WITH URINATION</p> <p>___ URINARY TRACT INFECTIONS</p> <p>___ BLOOD IN URINE</p> <p>___ STRAINING</p> <p> ___ BED WETTING</p> <p>___ URETHRAL DISCHARGE</p> <p>___ CLOUDY URINE</p> <p>___ OTHER _____</p> <p>_____</p> <p>_____</p>	
<p>MUSCULOSKELETAL</p> <p>___ MUSCLE PAIN ___ JOINT SWELLING</p> <p>___ MUSCLE WEAKNESS ___ JOINT DEFORMITIES</p> <p>___ MUSCLE CRAMPS ___ INJURIES</p> <p>___ TWITCHING ___ CURVATURE OF SPINE</p> <p>___ JOINT STIFFNESS ___ BACK PAIN</p> <p>___ JOINT PAIN ___ OTHER</p>		<p>PULMONARY</p> <p>___ CHEST CONGESTION ___ WHEEZING</p> <p>___ DIFFICULTY BREATHING ___ ASTHMA</p> <p>___ COUGHING BLOOD ___ PHLEGM</p> <p>___ SHORTNESS OF BREATH</p> <p>___ PERSISTENT COUGH</p> <p>___ PAIN IN LUNGS</p>	
<p>PSYCHIATRIC</p> <p>___ DEPRESSION ___ ANXIETY ___ SUICIDE ATTEMPT ___ DRUG USE</p>			
<p>CARDIOVASCULAR</p> <p>___ CHEST DISCOMFORT ___ DYSPNEA ON EXERTION ___ FAINTING ___ HEART MURMUR</p> <p>___ HIGH BLOOD PRESSURE ___ PALPITATIONS ___ ORTHOPNEA ___ PERIPHERAL EDEMA</p> <p>___ LEG CRAMPS AT REST ___ LEG CRAMPS ON EXERTION ___ VARICOSE VEINS ___ OTHER _____</p>			

VITALS (CLINIC USE ONLY)

HEIGHT: _____ WEIGHT: _____ BMI: _____ TEMP: _____ BP: _____ PULSE: _____