

PATIENT HISTORY

DATE _____ CHART NO. _____

NAME _____ DATE OF BIRTH _____ AGE _____

ALLERGIES TO MEDICATIONS: _____

MEDICATIONS

1. _____
2. _____
3. _____
4. _____
5. _____

REFERRAL M.D. _____

OCCUPATION _____

SOCIAL HISTORY: Marital status: M ___ S ___ D ___ W ___

Cigarettes (packs/day) _____ Alcohol (drinks/day) _____

Recreational Drugs _____

PRIOR SERIOUS ILLNESS / MEDICAL CONDITIONS:

Pertinent Medical History about your Family

1. _____
2. _____
3. _____
4. _____

1. _____
2. _____
3. _____
4. _____

HOSPITALIZATIONS / SURGERY (give date and reason):

1. _____
3. _____

2. _____
4. _____

REVIEW OF SYSTEMS (check all):

Yes No 1. General
 ___ ___ weight loss
 ___ ___ weakness / fatigue
 ___ ___ fever / night sweats

2. Eyes:
 ___ ___ dryness / redness
 ___ ___ blurred / double vision
 ___ ___ glaucoma

3. Heart and Circulation:
 ___ ___ chest pain
 ___ ___ irregular heartbeats
 ___ ___ heart murmur
 ___ ___ leg swelling
 ___ ___ high blood pressure
 ___ ___ rheumatic fever

4. Lungs:
 ___ ___ shortness of breath
 ___ ___ cough
 ___ ___ coughing up blood
 ___ ___ tuberculosis
 ___ ___ emphysema
 ___ ___ asthma

5. Stomach and Intestines:
 ___ ___ nausea / vomiting / diarrhea
 ___ ___ heartburn / reflux

Yes No
 ___ ___ jaundice/hepatitis
 ___ ___ spitting up blood
 ___ ___ black stools

6. Kidneys and Genitals:
 ___ ___ pain / burning on urination
 ___ ___ bloody / cloudy urine
 ___ ___ penile / vaginal discharge
 ___ ___ genital rash / ulcers
 ___ ___ venereal disease
 ___ ___ kidney stones

7. Muscles and Joints:
 ___ ___ muscle weakness / pain
 ___ ___ joint pain / swelling
 ___ ___ arthritis / gout

8. Skin and Glands:
 ___ ___ dryness
 ___ ___ rash
 ___ ___ growths / discoloration
 ___ ___ swollen glands

9. Neurological:
 ___ ___ headache
 ___ ___ numbness / weakness
 ___ ___ neuralgia
 ___ ___ off balance / dizziness

Yes No
 ___ ___ seizure
 ___ ___ stroke
 ___ ___ Bell's palsy

10. Psychiatric:
 ___ ___ anxiety
 ___ ___ depression
 ___ ___ delusions / hallucinations
 ___ ___ medications

11. Hormones:
 ___ ___ thyroid disorder
 ___ ___ diabetes ("sugar")
 ___ ___ irregular menses

12. Blood:
 ___ ___ bleeding tendency
 ___ ___ easy bruising
 ___ ___ anemia

13. Immune System:
 ___ ___ frequent infections
 ___ ___ positive HIV test

14. If Child:
 ___ ___ immunization up to date
 ___ ___ feeding difficulties

The information is to the best of my knowledge accurate and complete. PATIENT SIGNATURE: _____

Reviewed and updated. PHYSICIAN SIGNATURE: _____