PATIENT HISTORY FORM

Patient's Name____Date:___________________

It is helpful to gather information about your medical history for the physician to use in your examination. Please complete this form completely for the physician's review.

1. CONSTITUTIONAL SYMPTOMS

- Good general health lately ☐ No ☐ Yes
- Recent weight change ☐ No ☐ Yes
- Fever ☐ No ☐ Yes
- Fatigue ☐ No ☐ Yes
- Headaches ☐ No ☐ Yes

2. INTEGUMENTARY (Skin, Breast)

- Rash or Itching ☐ No ☐ Yes
- Change in skin color ☐ No ☐ Yes
- Change in hair or nails ☐ No ☐ Yes
- Varicose veins ☐ No ☐ Yes
- Breast pain ☐ No ☐ Yes
- Breast lump ☐ No ☐ Yes
- Breast discharge ☐ No ☐ Yes

3. NEUROLOGICAL

- Frequent or recurring headaches ☐ No ☐ Yes
- Lightheaded or dizzy ☐ No ☐ Yes
- Convulsions or seizures ☐ No ☐ Yes
- Numbness or tingling sensations ☐ No ☐ Yes
- Tremors ☐ No ☐ Yes
- Paralysis ☐ No ☐ Yes
- Stroke ☐ No ☐ Yes
- Head Injury ☐ No ☐ Yes

4. HEMATOLOGIC / LYMPHATIC

- Slow to heal after cuts ☐ No ☐ Yes
- Bleeding or bruising tendency ☐ No ☐ Yes
- Anemia ☐ No ☐ Yes
- Phlebitis ☐ No ☐ Yes
- Past transfusion ☐ No ☐ Yes
- Enlarged glands ☐ No ☐ Yes

5. PSYCHIATRIC

- Memory loss or confusion ☐ No ☐ Yes
- Nervousness ☐ No ☐ Yes
- Depression ☐ No ☐ Yes
- Insomnia ☐ No ☐ Yes

6. ENDOCRINE

- Glandular or hormone problem ☐ No ☐ Yes
- Thyroid disease ☐ No ☐ Yes
- Diabetes ☐ No ☐ Yes
  (Insulin or Non-Insulin – Circle one)
- Excessive thirst or urination ☐ No ☐ Yes
- Heat or cold intolerance ☐ No ☐ Yes
- Skin becoming dryer ☐ No ☐ Yes
- Change in hat or glove size ☐ No ☐ Yes

7. EYES, EARS, NOSE, MOUTH

- Hearing loss or ringing ☐ No ☐ Yes
- Earaches or drainage ☐ No ☐ Yes
- Chronic sinus problem or rhinitis ☐ No ☐ Yes
- Nose bleeds ☐ No ☐ Yes
- Mouth sores ☐ No ☐ Yes
- Bleeding gums ☐ No ☐ Yes
- Sore throat or voice change ☐ No ☐ Yes
- Swollen glands in neck ☐ No ☐ Yes

8. CARDIOVASCULAR

- Heart trouble ☐ No ☐ Yes
- Chest pain or angina pectoris ☐ No ☐ Yes
- Palpitation ☐ No ☐ Yes
- Shortness of breath with walking ☐ No ☐ Yes
- Swelling of feet, ankles, or hands ☐ No ☐ Yes

9. RESPIRATORY

- Chronic or frequent coughs ☐ No ☐ Yes
- Spitting up blood ☐ No ☐ Yes
- Shortness of breath ☐ No ☐ Yes
- Asthma or wheezing ☐ No ☐ Yes

10. MUSCULOSKELETAL

- Joint pain ☐ No ☐ Yes
- Joint stiffness or swelling ☐ No ☐ Yes
- Weakness of muscles or joints ☐ No ☐ Yes
- Muscle pain or cramps ☐ No ☐ Yes
- Back pain ☐ No ☐ Yes
- Cold extremities ☐ No ☐ Yes
- Difficulty in walking ☐ No ☐ Yes
- Sports injury ☐ No ☐ Yes

11. GASTROINTESTINAL

- Loss of appetite ☐ No ☐ Yes
- Change in bowel movements ☐ No ☐ Yes
- Nausea or vomiting ☐ No ☐ Yes
- Frequent diarrhea ☐ No ☐ Yes
- Constipation ☐ No ☐ Yes
- Rectal bleeding or blood in stool ☐ No ☐ Yes
- Abdominal pain ☐ No ☐ Yes
- Peptic ulcer (stomach or duodenal) ☐ No ☐ Yes

ALLERGIC / IMMUNOLOGIC

History of reaction to:

Medication ☐ No ☐ Yes

List: ____

Other ☐ No ☐ Yes

List: ____

12. GENITOURINARY

Frequent urination	☐ No	☐ Yes
Burning or painful urination	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes
Incontinence or dribbling	☐ No	☐ Yes
Kidney stones	☐ No	☐ Yes
Sexual difficulty	☐ No	☐ Yes
MALE – Testicle pain	☐ No	☐ Yes

FEMALE

Pain with periods	☐ No	☐ Yes
Use douche	☐ No	☐ Yes
Irregular periods	☐ No	☐ Yes
Vaginal discharge	☐ No	☐ Yes

Age at onset of menstruation: ______________________________

Number of day's menstruation lasts: ______________________________

Date of last pap smear: ______________________________

Date of last menstrual period: ______________________________

List all pregnancies with dates, weights, and problems (Please include miscarriages, terminations, and pre-term):

PAST MEDICAL HISTORY

Previous Hospitalizations / Surgeries / Serious Injuries

PATIENT SOCIA L HISTORY

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner

Use of Tobacco: ☐ Never ☐ Previously but quit ☐ Current packs per day: ________

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Drugs: ☐ Never ☐ Type/Frequency: ______________________________

Exposure to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne particles ☐ Noise

History of Domestic Violence: ☐ Verbal ☐ Physical ☐ Other: ______________________________

FAMILY MEDICAL HISTORY

	Age	Diseases	if deceased, cause of death
Father:			
Mother:			
Siblings:			
Spouse:			
Children:			

Patients Signature: ______________________________ Date: ________________

Physician Reviewed: ______________________________ Date: ________________