

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE ____/____/____ DATE OF LAST PHYSICAL EXAM ____ / ____ / ____
 LAST NAME _____ FIRST NAME _____ MIDDLE _____
 SOCIAL SECURITY NO. _____ DATE OF BIRTH ____ / ____ / ____

CHIEF COMPLAINT
 What is the main reason for your visit today? (Describe your problem in detail)

History of Present Illness

Please answer the following questions

Location of the problem Front Back
 Abdomen Back Leg
 Other _____

On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem
 1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?
 2 days ago 2 weeks ago 1 month ago
 Other _____

Does anything help or make the problem worse?
 Moving around Standing up Lying on my side
 Other _____

How long does the problem last?
 30 minutes 1 hour It is always there
 Other _____

Is anything else occurring at the same time?
Yes No If yes, please explain.
 Nausea Rash Headaches
 Other _____

Is the problem constant or variable?
 Dull then Sharp Very sharp then leaves Always there
 Other _____

Does the problem interfere with your normal functions?
Yes No If yes, please explain _____

Physician use only: (Comments/Notes)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"># Answers</td> <td style="text-align: center;">Level of Service</td> </tr> <tr> <td style="text-align: center;">1 - 3</td> <td style="text-align: center;">1 or 2</td> </tr> <tr> <td style="text-align: center;">4+</td> <td style="text-align: center;">3 - 5</td> </tr> </table>	# Answers	Level of Service	1 - 3	1 or 2	4+	3 - 5
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1 - 3	1 or 2						
4+	3 - 5						

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.)

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery	Date

Are you on any medications? **Y N (If yes, list all)**

Are you on a special diet? **Y N (If yes, please explain)**

Do you smoke? **Y N**
 If yes, how much? _____
Do you drink? **Y N**
 If yes, how much? _____

Do you have allergies? **Y N (If yes, please explain)**

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