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

	CAL EXAM//	
AST NAME		MIDDLE
Social Security No DATE OF BII	rth <u>/</u>	•
CHIEF COMPLAINT What is the main reason for your visit today? (De	escribe your problem in de	tail)
	Prèsent Ilines:	\$
Location of the problem Abdomen Back Leg Other	How long does the p	
On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?	Is anything else occ Yes No If Nausea	urring at the same time?
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	Is the problem cons Dull then Sharp V Other	tant or variable? ery sharp then leaves Always there
Does anything help or make the problem worse? Moving around Standing Up Lying on my side Other	tions?	If yes, please explain
Physician use only: (Comments/Notes)		
		# Answers Level of Service 1 - 3 1 or 2 4+ 3 - 5
•		
Past Medic List all serious illnesses in your immediate family. (Exame	al & Social Hi	
List all serious illnesses in your immediate family. (Example 1) List any personal past illnesses and/or surgeries and when they occurred. Illness or Surgery Date	mple: diabetes, tuberculosi	s, breast cancer, heart disease, etc.,)
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Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in space provided

Constitutional Sympton	ns		Integumentary		
Fever		N	Skin rash	Υ	N
Chills	Υ	N	Boils	Υ	N
Headache			Persistent itch	Y	Ń
Other			Other		
Eyes			Musculoskeletal		
Blurred vision			Joint pain	Υ	. N
Double vision			Neck pain	Υ	N
Pain			Back pain	Υ	· N
Other			Neck pain Back pain Other		
Allergic/Immunologic			Lai/Nose/Titloadinoatii		
Hay Fever	Υ	N	Ear infection	Υ	N
Drug allergies			Sore throat	Υ	N
Other			Sinus problems	Υ	N
Neurological	-		Other		
Tremors .	Υ	N	Sinus problems Other Genitourinary		٠.
Dizzy spells	Υ	N	Urine retention	Υ	Ν
Numbness/tingling			Painful urination	Υ	N
Other		14	Urinary frequency	Υ	N
		•	Urinary frequency Other		
Endocrine .			Respiratory		
Excessive thirst Too hot/cold	Y	N	Wheezing	Υ	N
		N	Frequent cough	Ÿ	N
Tired/sluggish		N	· · · · · · · · · · · · · · · · · · ·	•	
Other			Shortness of breath	Ÿ	N
Gastrointestinal			Other		
Abdominal pain Nausea/vomiting	Υ	N	Hematologic/Lymphatic		
Nausea/vomiting	Υ	N	Swollen glands	Y	• •
Indigestion/heartburn	Υ	N	Blood clotting problem	Υ	N
Other			Other		
Cardiovascular			Psychologic	4	
Chest pain	Υ	N	Are you generally satisfied with your life?	Y	N
Varicose veins	Υ	N	Do you feel severely depressed?	Υ	N
High blood pressure Other		N	Have you considered suicide? Other	Υ	N

ysician use only: (Comments/Notes)

Level of
Service
1 or 2
3 ··· · · · · · · · · · · · · · · · · ·
4 or 5

sician:	Date:	//	<u>'</u>