

Name \_\_\_\_\_

**General Patient Questions**

Age \_\_\_\_\_

Reason for Visit \_\_\_\_\_

General History		
Alcoholism	Yes	No
Anemia	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Bleeding tendency	Yes	No
Blood clots	Yes	No
Blood transfusion	Yes	No
Breast cancer	Yes	No
Bronchitis	Yes	No
Cancer	Yes	No
Colon cancer	Yes	No
COPD	Yes	No
Deep vein thrombosis	Yes	No
Depression	Yes	No
Diabetes	Yes	No
Dialysis	Yes	No
Eczema	Yes	No
Emphysema	Yes	No
Epilepsy	Yes	No
Glaucoma	Yes	No
Heart attack	Yes	No
Heart failure	Yes	No
Hemorrhoids	Yes	No

Hepatitis A	Yes	No
Hepatitis B or C	Yes	No
Hernia	Yes	No
High blood pressure	Yes	No
High thyroid	Yes	No
HIV / AIDS	Yes	No
Hives	Yes	No
Illicit drug use	Yes	No
Keloid formation	Yes	No
Kidney disease	Yes	No
Liver disease	Yes	No
Low thyroid	Yes	No
Lung cancer	Yes	No
Lupus	Yes	No
Migraines	Yes	No
Mitral valve prolapse	Yes	No
Pneumonia	Yes	No
Prostate cancer	Yes	No
Seizure	Yes	No
Stroke	Yes	No
Tuberculosis	Yes	No
Ulcer	Yes	No

<b>Comments</b>

Activity Level	
Fully active	0
Restricted in strenuous activity, able to do light work	1
Can walk, provide all self care, moves more than 50% while awake	2
Limited self care, confined to bed more than 50% while awake	3
Disabled, no self care, completely confined to bed or chair	4

Social History	Type / Frequency / How long		
Alcohol use	Yes	No	
Tobacco use	Yes	No	
Recreational drug use	Yes	No	

Name \_\_\_\_\_

Previous Hospitalizations	Year

Previous Surgery	Year

Active Medical Problems	Onset

Allergies	Symptoms

Family History	Alive		Medical Problems
	Yes	No	
Mother	Yes	No	
Father	Yes	No	
Brother	Yes	No	
Sister	Yes	No	
	Yes	No	
	Yes	No	

Medications	Reason

<b>Review of Systems</b>	<b>Circle all that apply</b>	
<b>Constitutional Symptoms</b> Good general health Recent weight loss Recent weight gain Fever Chills Fatigue Night Sweats	<b>Eyes</b> Wear glasses Wear contact lenses Blurred or double vision Cataracts	<b>Gastrointestinal</b> Heartburn Loss of appetite Change in bowel movements Nausea or vomiting Diarrhea Constipation Painful bowel movements Blood in bowel movements Abdominal pain
	<b>Ears / Nose / Mouth / Throat</b> Hearing loss Ringing in the ears Earaches Drainage from ears Sinus problem Runny nose Nose bleeds Mouth sores Bleeding gums Bad breath Voice change Sore throat Swollen glands in neck	
<b>Cardiovascular</b> Heart trouble Palpitations Chest pain or angina pectoris Shortness of breath with walking Shortness of breath lying flat Swelling of feet or ankles Varicose veins Deep vein thrombosis (DVT) Sores on feet or ankles Phlebitis Blood clots in legs Leg cramps when walking	<b>Musculoskeletal</b> Back pain Pain radiating down legs Joint pain Hip pain Knee pain Shoulder pain Joint stiffness Joint swelling Weakness of muscles Weakness of joints Muscle cramps Muscle pain Cold extremities Difficulty walking	<b>Allergic/Immunologic</b> Prior adverse reaction to: Penicillin or other antibiotics Morphine or other narcotics Lidocaine or other anesthetics Aspirin or other pain remedies Iodine Betadine
		<b>Respiratory</b> Chronic or frequent coughs Shortness of breath Wheezing Emphysema Coughing up blood
<b>Genitourinary</b> Burning or painful urination Blood in urine Change in force of stream Incontinence or dribbling Kidney stones Sexual difficulty	<b>Hematologic/Lymphatic</b> Slow to heal after cuts Bleeding or bruising tendency Anemia Past transfusion Date of last transfusion Enlarged glands	<b>Psychiatric</b> Memory loss Nervousness Depression Confusion Insomnia
<b>Endocrine</b> Glandular or hormone problem Excessive thirst or urination Heat or cold intolerance Skin becoming dryer		