Patient History

Patient name: _____

Date of birth (mm/dd/yy):_____

Please list all past/current medical conditions:

_____
_____
_____
_____
_____
_____
_____
_____

Please list all past surgeries:

_____
_____
_____
_____

Please list current medications (including over-the-counter or herbal preparations):

_____
_____
_____
_____
_____
_____

Please list all medication allergies:

_____
_____
_____
_____

Review of Systems: How are you feeling today?

GENERAL

Symptom	Yes	No
Fever	___	___
Chills	___	___
Sweats	___	___
Anorexia (loss of appetite)	___	___
Fatigue (tiredness)	___	___
Malaise (feeling run down)	___	___
Weight loss	___	___

EYES

Symptom	Yes	No
Change in vision	___	___
Blurring	___	___
Diplopia (seeing double)	___	___
Vision loss	___	___
Eye pain	___	___
Photophobia (light sensitivity)	___	___

EARS/NOSE/THROAT

Symptom	Yes	No
Change in hearing	___	___
Earache	___	___
Ear discharge	___	___
Tinnitus (ringing in ears)	___	___
Decreased hearing	___	___
Nasal congestion	___	___
Nosebleeds	___	___
Sore throat	___	___
Hoarseness	___	___
Dysphagia (difficulty swallowing)	___	___

CARDIOVASCULAR

Symptom	Yes	No
Chest pain	___	___
Palpitations (rapid heartbeat)	___	___
Syncope (fainting)	___	___
Dyspnea on exertion (shortness of breath)	___	___
Orthopnea (shortness of breath while lying down)	___	___
PND (shortness of breath waking you from sleep)	___	___
Leg edema (swelling)	___	___

RESPIRATORY

Symptom	Yes	No
Nausea/vomiting	___	___
Shortness of breath	___	___
DOE (breathlessness)	___	___
Anorexia (loss of appetite)	___	___
Cough	___	___
Dyspnea (shortness of breath)	___	___
Excessive sputum (mucus)	___	___
Hemoptysis (coughing blood)	___	___
Wheezing	___	___

GASTROINTESTINAL

Symptom	Yes	No
Nausea	___	___
Vomiting	___	___
Diarrhea	___	___
Constipation	___	___
Change in bowel habits	___	___
Abdominal pain	___	___
Jaundice (yellowing of skin/eyes)	___	___
Bloody/tarry stools	___	___

GENITOURINARY

Symptom	Yes	No
Joint Pain	___	___
Dysuria (pain on urination)	___	___
Hematuria (blood in urine)	___	___
Penile or vaginal discharge	___	___
Urinary frequency	___	___
Urinary hesitancy	___	___
Nocturia (waking to urinate)	___	___
Incontience	___	___
Genital sores	___	___
Impotence	___	___
Decreased libido	___	___

MUSCULOSKELETAL

Symptom	Yes	No
Back pain	___	___
Joint pain	___	___
Joint swelling	___	___
Muscle cramps	___	___
Muscle weakness	___	___
Stiffness	___	___
Arthritis	___	___

SKIN

Symptom	Yes	No
Rash	___	___
Itching	___	___
Dryness	___	___
Suspicious lesions (skin spots that are concerning to you)	___	___
Changing moles	___	___
Breast problems	___	___

NEUROLOGIC

Symptom	Yes	No
Headache	___	___
Dizzyness	___	___
Numbness	___	___
Paresthesia (burning or prickling sensation)	___	___
Temporary paralysis	___	___
Weakness	___	___
Seizures	___	___
Syncope (fainting)	___	___
Tremors	___	___
Vertigo	___	___

SOCIAL HISTORY

Married Widowed Divorced Separated Single

_____ _____ _____ _____ _____

FAMILY SIZE

Number of people in household: _____

Smokers in household? _____

EDUCATION LEVEL ATTAINED:

_____

EMPLOYER

_____

Tobacco:

Every day____ Some days ____
Current status unknown ____
Former smoker____ Never smoker ____
Unknown if ever smoked ____
2nd-hand smoke exposure? Y ____ N____

Year started: _____ Year quit: _____

Counseled to cut down: Y____ N____

Drug use:

Current___ Previous ____ Never ____

Cocaine___ Crack___ Heroin___ Meth___

Ecstasy___ Marijuana___ Illicit Rx___

Alcohol use:

Denies___ Rare___ Social___ Weekly___ Daily___
Drinks/day: _____ Counseled: Y N

PSYCHIATRIC

Symptom	Yes	No
Depression	___	___
Anxiety	___	___
Memory loss	___	___
Mental disturbance	___	___
Suicidal ideation	___	___
Hallucinations	___	___
Paranoia	___	___

ENDOCRINE

Symptom	Yes	No
Cold intolerance	___	___
Heat intolerance	___	___
Polydipsia (excessive thirst)	___	___
Polyphagia(excessive hunger)	___	___
Polyuria (excessive urination)	___	___
Weight change	___	___

HEME/LYMPHATIC

Symptom	Yes	No
Abnormal bruising	___	___
Bleeding	___	___
Enlarged lymph nodes	___	___
LAD	___	___

ALLERGY/IMMUNOLOGIC

Symptom	Yes	No
Urticaria (hives or rash)	___	___
Hay fever	___	___
Persistent infections	___	___
HIV exposure	___	___
Seasonal allergies	___	___
Contact allergies (metal, latex, dyes, fragrences)	___	___

FAMILY HISTORY

Symptom	Mother	Father	Brother	Sister	Grandmother	Grandfather
Autoimmune disease	_____	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____	_____
Blood disorders	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____	_____	_____
High cholesterol	_____	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Alcoholism	_____	_____	_____	_____	_____	_____
Breast Cancer	_____	_____	_____	_____	_____	_____
Ovarian Cancer	_____	_____	_____	_____	_____	_____
Colon Cancer	_____	_____	_____	_____	_____	_____
Osteoperosis	_____	_____	_____	_____	_____	_____
Psychiatric conditions	_____	_____	_____	_____	_____	_____
Substance abuse	_____	_____	_____	_____	_____	_____
Family history unknown	_____	_____	_____	_____	_____	_____