



PATIENT HISTORY

Patient's Name: _____ Height: _____ Weight: _____ Today's Date: _____

Social Security #: _____ Age: _____ Date of Birth: _____

Name of Primary Care/Family Physician: _____

Emergency Contact: _____ Phone #: _____
(Name) (Relationship to patient)

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Have you been treated for this problem? No Yes

Date of injury / Onset of problem: _____

Current problem is the result of a(n): *Check all that apply.*

Car Accident Work Accident Other Accident State in which accident occurred: _____

MEDICAL HISTORY Are you currently receiving treatment or have you received treatment in the past for any of the following conditions?

Yes	No		Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems			
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis/Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	TB
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	Psychological	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infection	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever			
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever			

Please specify any other medical problems: _____

DRUG ALLERGIES Please describe any current or past drug reactions.

Allergy to (drug name)	Reactions (itching, cough, hives, etc.)	How is/was reaction treated?

I DO NOT have any known drug allergies.

SURGICAL HISTORY & HISTORY OF HOSPITALIZATION

Surgery/Hospitalizations	Year	Complications, if any

I DO NOT have a history of surgery or hospitalization.

Have you ever had any problems with anesthesia? No Yes - describe: _____

Reviewed by: _____

Over please

FAMILY HISTORY Have your mother, father, grandparents, brothers or sisters been treated in the past or are they currently receiving treatment for any of the following conditions?

- Cancer
 Diabetes
 Heart Disease
 Tuberculosis
 Kidney Disease
 Arthritis
 None of these
 Other (specify): _____

PLEASE LIST HEALTH STATUS OR CAUSE OF DEATH FOR THE FOLLOWING FAMILY MEMBERS:

Mother: _____ Father: _____

SOCIAL HISTORY

- Marital Status: Single
 Married
 Divorced
 Separated
 Widowed

 Employed – occupation: _____
 Work in home
 Student
 Retired

 Do you have children? No
 Yes – number: _____
 Do you live alone? No
 Yes

 Do you smoke currently? No
 Yes – number: _____ packs per day for _____ years.

 Do you consume alcohol products? No
 Yes – amount and frequency: _____

REVIEW OF SYSTEMS Please check the following symptoms you have experienced on a regular basis:

- | | | | |
|---|--|--|--|
| GENERAL
<input type="checkbox"/> Fever
<input type="checkbox"/> Night sweats
<input type="checkbox"/> Weight gain
<input type="checkbox"/> Weight loss | EYES
<input type="checkbox"/> Blurring
<input type="checkbox"/> Eye strain
<input type="checkbox"/> Glasses/contacts
<input type="checkbox"/> Discharge | THROAT
<input type="checkbox"/> Soreness
<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Difficulty swallowing | GASTROINTESTINAL
<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting
<input type="checkbox"/> Belching
<input type="checkbox"/> Diarrhea |
| SKIN
<input type="checkbox"/> Eruptions/rashes
<input type="checkbox"/> Cyanosis (bluish tint)
<input type="checkbox"/> Jaundice (yellow tint) | EARS
<input type="checkbox"/> Deafness
<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Pain
<input type="checkbox"/> Discharge | GENITOURINARY
<input type="checkbox"/> Pain
<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Incontinence | NEUROMUSCULAR
<input type="checkbox"/> Weakness
<input type="checkbox"/> Joint pain
<input type="checkbox"/> Tingling
<input type="checkbox"/> Varicosity
<input type="checkbox"/> Deformities |
| HEAD
<input type="checkbox"/> Headache
<input type="checkbox"/> Fainting/blackouts
<input type="checkbox"/> Trauma | NOSE
<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Obstruction | CARDIOVASCULAR
<input type="checkbox"/> Chest pain
<input type="checkbox"/> Rapid/throbbing heartbeat
<input type="checkbox"/> Faintness
<input type="checkbox"/> Fluid/swelling in extremities | RESPIRATORY
<input type="checkbox"/> Chest pain
<input type="checkbox"/> Difficulty breathing
<input type="checkbox"/> Bloody sputum
Date of last chest x-ray:
_____ |

FEMALE REPRODUCTIVE

Are you or could you be pregnant? No Yes

MEDICATIONS Please list all medications you take **with or without a prescription** (use additional paper if needed).

Medication name	Dosage/# per day	Reason for taking	Side effects

Patient's signature: _____ Date: _____
 Reviewed by: _____, M.D. Date: _____

Annual update to be completed after one year: There are NO CHANGES to the above information in my medical history.

Patient's Signature: _____ Date: _____