PATIENT HISTORY FORM

Last Name: _____ **First Name:** _____ **Middle Initial:** ___

Today's Date: _____ Date of last Physical Exam: _____

Social Security Number: _____ DOB: _____

Chief Complaint

What is the main reason for your visit today?

_____

_____

History of Present Illness

Please answer the following questions

Where is the problem located?
Kidney Bladder Prostate Scrotum
Other_____

On a scale of 1-10 with 10 being most severe,
what number best describes the problem? _____

How long has the problem existed?
□ 1-2 days □ 2 weeks □ 1 month □ Over 1 year
Other: _____

Does anything ease the problem or make it worse?
□ Sitting/Standing □ Lying Down □ Pressure
Other: _____

How long does the problem last?
□ 30 min □ 1 hour □ It's always there
Other: _____

Are there other symptoms associated with this problem?
□ Fever/Chills □ Nausea/Vomiting □ Rash □ Headache
Other: _____

Is the problem constant or intermittent?
Describe: _____

_____

Social History

(Circle response)

Do you use tobacco products? (circle) **Currently / Formerly / Never**
Type: _____ **How much?** _____

Do you drink? Yes / No How much? _____

Are you employed? Yes / No
Full Time Part Time Retired Disabled

Married / Single / Divorced / Widowed

Who is currently living in your household?

_____

Past Medical

Have you had any surgical procedures?

What	**When**

Please check all that apply
I have a **personal** history of:
□ Cancer (TYPE) _____ □ Heart Disease
□ Diabetes □ High Blood Pressure □ Kidney Disease
□ Stroke □ Seizure □ Stomach Ulcer
□ Cataract □ Glaucoma □ Other: _____

_____

I have a **family** history of:
(Immediate family members. Please specify maternal or paternal side when referring to grandparents, etc)

Problem	Relationship
□ Cancer (TYPE) _____	
□ Heart Disease	
□ Diabetes	
□ High Blood Pressure	
□ Kidney Disease	
□ Other: _____	

_____

Family Status

Relationship	Alive or Deceased		Cause	Age
Mother	A	D		
Father	A	D		
Brother	A	D		
Brother	A	D		
Sister	A	D		
Sister	A	D		

Female Patients Only

Do you have menstrual periods? Yes / No
If yes, are they regular? Yes / No
When was your last menstrual period? _____
Is there a chance you may be pregnant? _____

Name: _____ DOB: _____ Date: _____

Are you allergic to any medications? Yes / No If yes, please list:

_____

Please list current medications:

_____

_____

_____

Review of Systems

Are you currently experiencing any of the following? Circle **Yes** or **No**

EYES

Blurred vision	Yes / No
Double vision	Yes / No
Pain	Yes / No

ENT

Ear pain	Yes / No
Sore throat	Yes / No
Sinus problems	Yes / No

Cardiovascular

Chest pain	Yes / No
Varicose veins	Yes / No
Angina	Yes / No
Syncope (Fainting)	Yes / No

Respiratory

Shortness of Breath	Yes / No
Wheezing	Yes / No
Frequent Cough	Yes / No

Gastrointestinal

Abdominal Pain	Yes / No
Nausea	Yes / No
Vomiting	Yes / No
Indigestion	Yes / No
Heartburn	Yes / No

Musculoskeletal

Joint pain	Yes / No
Neck pain	Yes / No
Back pain	Yes / No

GENITOURINARY

Urinary Retention	Yes / No
Painful Urination	Yes / No
Urinary Frequency	Yes / No

Integumentary

Skin rash	Yes / No
Boils	Yes / No
Persistent itch	Yes / No

Neurological

Tremors	Yes / No
Dizzy spells	Yes / No
Numbness / Tingling	Yes / No

Psychological

Are you generally satisfied with your life?	Yes / No
Depression	Yes / No
Thoughts of suicide	Yes / No
Anxiety	Yes / No

Endocrine

Excessive thirst	Yes / No
Cold intolerance	Yes / No
Heat intolerance	Yes / No
Tired / Sluggish	Yes / No

Hematologic / Lymphatic

Swollen glands	Yes / No
Blood clotting problems	Yes / No

Immunologic

Hay Fever	Yes/No

Constitutional symptoms

Fever	Yes / No
Chills	Yes / No
Weight Loss	Yes / No

Physician Signature: _____ **Date:** _____