

PATIENT HISTORY FORM – page 1 of 2

Today's Date: ___/___/___

Date of Birth: ___/___/___

Last Name: _____


First Name: _____

Chief Complaint:

What is the main reason for your visit today? (Describe your problems in detail)

History of Present Illness

Please answer the following questions

<p>Location of the problem Abdomen, Back, Leg, Head, Other</p> <hr/> <hr/> <div style="text-align: center;">  <p>Front Back</p> </div> <p>On a Scale of 1-10, with 10 being the most severe, circle the number that describes the problem? 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10</p> <p>When did you first notice the problem? 2 days ago, 2 weeks ago, 1 month ago, other _____</p>	<p>Does anything help or make the problem worse? Moving around, standing up, and lying on my side, other _____</p> <p>How long does the problem last? 30 minutes, 1 hour, it is always there, other _____</p> <p>Is anything else occurring at the same time? No Yes - please explain: Nausea, Rash, Headaches, other _____</p> <p>Is the problem constant or variable? Dull then sharp, Very sharp then leaves, Always there, other _____</p> <p>Does the problem interfere with your normal functions? No Yes - please explain: _____</p>
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Past Medical History

List all your illnesses since you were born

(Example: Diabetes, Heart Disease, Lung Disease, Cancer, etc)

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Past Surgical History

List all procedures that required anesthesia with dates
(Example: surgeries, endoscopy, colonoscopy)

<u>Surgery/Procedure</u>	<u>Date</u>	<u>Surgery/Procedure</u>	<u>Date</u>
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___

List of Medications / Supplements with Doses

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any allergies

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you exercise? No Yes

If Yes, how often? _____ What kind of exercise do you do? _____

Have you ever smoked? No Yes

If Yes, how much per day? _____ For how long? _____ If quit, when did you quit? _____

If you continue to smoke, how much per day? _____ How long have you been smoking? _____

Do you drink alcohol? No Yes

If Yes, how much? _____ How often? _____

Do you follow any diet? No Yes

if Yes, what kind?

What kind of work do you do or used to do?

Any occupational or toxic exposure in the past or currently?

What do you do for relaxation and any hobbies?
