

MR# \_\_\_\_\_

# Comprehensive Patient History

(see both sides)

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date: \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

**Describe the following:**

Location: \_\_\_\_\_ How long have you had this problem? \_\_\_\_\_

How severe is this problem?  mild  moderate  very How often are you having the problem? \_\_\_\_\_

What caused the problem? \_\_\_\_\_

Do you know of anything else that may have contributed to this problem? \_\_\_\_\_

Does anything else occur with this problem? \_\_\_\_\_

Additional Comments:

List previous hospitalizations/Surgeries/Serious Injuries	When?	List any medications you have.
_____	_____	1) _____
_____	_____	2) _____
_____	_____	3) _____
_____	_____	4) _____
		5) _____
		6) _____
		7) _____
		8) _____
		9) _____
		10) _____
		<b>Allergies:</b> _____

*Patient Social History*

Marital Status:  Single  Married  Separated  Divorced  Widowed

Use of alcohol:  Never  Rarely  Moderate  Daily \_\_\_\_\_

Use of tobacco:  Never  Previously but quit  Current packs per day \_\_\_\_\_

Use of Drugs:  Never  Type/Frequency \_\_\_\_\_

Excessive exposure at home or work to:  Fumes  Dust  Solvents  Noise

Occupation: \_\_\_\_\_

Caffeine \_\_\_\_\_

Have you ever had the following?

Cancer.....	yes	no	Convulsions.....	yes	no	Heart trouble.....	yes	no
Serious infections.....	yes	no	Venereal Disease.....	yes	no	Bleeding Tendency.....	yes	no
Diabetes.....	yes	no	Depression/Mental Illness.....	yes	no	Hereditary Defects.....	yes	no
Stroke.....	yes	no	Hypertension.....	yes	no	High Cholesterol.....	yes	no

Family Medical History

	<u>Age</u>	<u>Diseases</u>	<u>If Deceased, Cause of Death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

**Have you recently experienced any of the following?**

PLEASE ANSWER ALL QUESTIONS

CONSTITUTIONAL

Good general health lately.....	No	Yes
Recent weight change.....	No	Yes
Fever.....	No	Yes
Fatigue.....	No	Yes
Headaches.....	No	Yes

EYES

Eye disease or injury.....	No	Yes
Wear glasses/contact lens.....	No	Yes
Blurred or double vision.....	No	Yes
Glaucoma.....	No	Yes

ENT

Hearing loss.....	No	Yes
Ringing in the ears.....	No	Yes
Earaches or drainage.....	No	Yes
Sinus problems.....	No	Yes
Nose bleeds.....	No	Yes
Mouth sores.....	No	Yes
Bleeding gums.....	No	Yes
Bad breath or bad taste.....	No	Yes
Sore throat or voice change.....	No	Yes
Swollen glands in neck.....	No	Yes

CARDIOVASCULAR

Heart trouble.....	No	Yes
Chest pains.....	No	Yes
Sudden heart beat changes.....	No	Yes
Swelling of feet, ankles or hands.....	No	Yes

RESPIRATORY

Frequent coughing.....	No	Yes
Spitting up blood.....	No	Yes
Shortness of breath.....	No	Yes
Asthma or wheezing.....	No	Yes

GASTROINTESTINAL

Loss of appetite.....	No	Yes
Change in bowel movements.....	No	Yes
Nausea or vomiting.....	No	Yes
Frequent diarrhea.....	No	Yes
Painful bowel movements or constipation..	No	Yes
Blood in stool.....	No	Yes
Stomach pain.....	No	Yes

GENITOURINARY

Frequent urination.....	No	Yes
Burning or painful urination.....	No	Yes
Blood in urine.....	No	Yes
Change of force of strain when urinating....	No	Yes
Incontinence or dribbling.....	No	Yes
Kidney stones.....	No	Yes
Sexual dysfunction.....	No	Yes

Date

MUSCULOSKELETAL

Joint pain.....	No	Yes
Joint stiffness or swelling.....	No	Yes
Weakness of muscles or joints.....	No	Yes
Muscle pain or cramps.....	No	Yes
Back pain.....	No	Yes
Cold extremities.....	No	Yes
Difficulty in walking.....	No	Yes

Date

SKIN

Rash or itching.....	No	Yes
Change in skin color.....	No	Yes
Change in hair or nails.....	No	Yes
Varicose veins.....	No	Yes
Breast pain.....	No	Yes
Breast lump.....	No	Yes
Breast discharge.....	No	Yes

NEUROLOGICAL

Frequent or recurring headaches.....	No	Yes
Light headed or dizzy.....	No	Yes
Convulsions or seizures.....	No	Yes
Numbness or tingling sensations.....	No	Yes
Tremors.....	No	Yes
Paralysis.....	No	Yes
Stroke.....	No	Yes

PSYCHIATRIC

Memory loss or confusion.....	No	Yes
Nervousness.....	No	Yes
Depression.....	No	Yes
Sleep problems.....	No	Yes

ENDOCRINE

Glandular or hormone problem.....	No	Yes
Thyroid disease.....	No	Yes
Excessive thirst or urination.....	No	Yes
Heat or cold intolerance.....	No	Yes
Dry skin.....	No	Yes
Change in hat or glove size.....	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts.....	No	Yes
Easily bruise or bleed.....	No	Yes
Anemia.....	No	Yes
Phlebitis.....	No	Yes
Past transfusion.....	No	Yes
Enlarged glands.....	No	Yes

Patient Signature: \_\_\_\_\_

Provider Signature: \_\_\_\_\_