

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE ____/____/____ DATE OF LAST PHYSICAL EXAM ____/____/____

LAST NAME _____ FIRST NAME: _____

NAME OF PHYSICIAN REQUESTING THIS EVALUATION _____ DATE OF BIRTH: ____/____/____

CHIEF COMPLAINT

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

History of Present Illness

Please answer the following questions

Location of the problem



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

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago
Other _____

Does anything help or make the problem worse?

Moving around Standing up Lying on my side
Other _____

How long does the problem last?

30 minutes 1 hour It is always there

Other _____

Is anything else occurring at the same time?

Yes No If yes, please explain.

Nausea Rash Headaches

Other _____

Is the problem constant or variable?

Dull then Sharp Very sharp then leaves Always there

Other _____

Does the problem interfere with your normal functions?

Yes No If yes, please explain

Past Medical, Family & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.,)

List any personal past illness and/or surgeries and when they occurred.

Illness or Surgery Date

Are you on a special diet? Yes No (If Yes, please explain)

Do you have allergies? Yes No (If Yes, please explain)

Do you smoke? Yes No

If yes, how much? _____

Do you drink? Yes No

If yes, how much? _____

Do you exercise regularly? Yes No

If yes, how much? _____

Are you currently taking any medication? If Yes, please list all.

