

PATIENT HISTORY FORM (PLEASE PRINT)

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

NAME: _____
Last First Middle TODAY'S DATE: _____

BIRTH DATE: _____ AGE: _____ S.S.#: _____

DATE OF LAST PHYSICAL EXAM: _____

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

- Abdomen Back Leg
 Other _____

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 Laying down
 Other _____

How long does the problem last?

- 30 minutes 1 hour It is always there
 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 _____

SOCIAL HISTORY

- Do you smoke? Yes No
If yes, which, Cigarettes Cigars Pipe
How much daily? _____ Number of years _____
Have you ever smoked? Yes No
If yes, when did you stop? _____
Do you regularly drink alcohol? Yes No
Type: _____ Amount _____
Are you on a special diet? Yes No
If yes, type: _____

FAMILY HISTORY

- | | | | |
|---|------------------------------|-----------------------------|---------------------|
| Stones | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relation _____ |
| Prostate Ca. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed | | | |
| Number of children _____ | | | |
| Do you work? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Position _____ |
| Are you retired? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Position held _____ |