COMPREHENSIVE PATIENT HISTORY

Date: ______________

NAME ____ SEX M F AGE______ BIRTHDATE__________
First Middle Last

Reason for visit today:____

How long have you had the problem?__________________ How often have you had the problem?____________________

Do you know of anything that may have contributed to this problem?_______________________________________

HT:__________ **WT:**____________

ALCOHOL USE: ___Abstain

/ Week:______contains 0.5 oz alcohol.____glasses wine____shots liquor____cans beer

TOBACCO USE: ___Never Second hand smoke exposure _____yes______no

___cigarettes ___pipe ___cigars

___Former Smoker______ # years______ packs/day ___________ quit date

___Current Smoker _____ # years ______ packs/day Desire to quit ___yes___no

___Smokeless tobacco ____current ____ former (date quit____________)

___snuff ___chew

Marital Status: ___Single ___Married ___Separated ___Divorced ____Widowed

Children: # daughters __________ # sons ___________

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (please circle positives)

Allergies	Cancer	Hypertension	Stroke
Anemia	Clotting Disorder	Kidney Disease	Substance Abuse
Arthritis	Diabetic	Neuro/Muscular Disease	Thyroid
Asthma	Reflux	Seizure	Ulcer

LIST PREVIOUS SURGERIES/CHRONIC ILLNESSES/HOSPITALIZATIONS/SERIOUS INJURIES **DATE**

FAMILY MEDICAL HISTORY:

	AGE	Diseases/illnesses	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Children			

CONTINUED ON BACK

PATIENT NAME: ____ DATE: ____________________

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING IN THE PAST 2 MONTHS? PLEASE CIRCLE POSITIVES

CONSTITUTIONAL
Decrease appetite
Chills
Fatigue
Fever
Sweats
Weight Loss
Weight Gain
Night Sweats

EYES
Cataracts
Glaucoma
Redness
Visual Disturbance

RESPIRATORY
Asthma
Chronic Bronchitis
Cough
Shortness of Breath
Wheezing

CARDIOVASCULAR
Chest Pain
Irregular Heartbeat
Palpitations

GASTROINTESTINAL
Vomiting
Difficulty Swallowing
Pain with Swallowing
Reflux
Heartburn

GENITOURINARY
Increased Frequency
Blood in Urine
Urgency

SKIN
Rash
Change in Skin Color

HEME/LYMPHATIC
Bleeding
Easy Bruising
Tender Lymph Nodes

MUSCULOSKELETAL
Joint Pain
Back Pain
Muscle Pain
Neck Pain

NEUROLOGIC
Dizzy
Difficulty Walking
Headaches
Memory Problems
Altered Sensation (i.e numbness etc)

PSYCHIATRIC
ADHD
Anxiety
Depression

ENDOCRINE
Excess Thirst/Hunger
Temperature Intolerance
Hot Flashes

ALLERGY/IMMUNOLOGY
Anaphylaxis
Hayfever
Food Allergies
Allergic Eyes

ENT
Ear drainage, earache, hearing loss, hoarseness
nasal congestion, snoring, sorethroat, tinnitus

MEDICATIONS: (PLEASE LIST NAME, DOSE, # TIMES PER DAY TAKEN)-include non-prescription

____
____
____
____
____
____
____
____
____
____
____

ALLERGIES : (PLEASE INCLUDE REACTION)

____
____
____
____