

# PATIENT HISTORY QUESTIONNAIRE

Your answers on this form will help your provider understand your medical concerns and conditions better. This form will be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you!**

TODAY'S DATE \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DOB \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

Approximate date symptoms started: \_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICINES?  YES  NO If yes, please list: \_\_\_\_\_

IS VISIT RELATED TO WORK OR AUTO INJURY?  YES  NO Date of injury \_\_\_\_\_

PLEASE LIST ALL PAST OPERATIONS AND SERIOUS ILLNESSES:

<u>Operation or Illness</u>	<u>Month and Year</u>	<u>City, State</u>
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>Recent x-rays, labs or tests</u>	<u>Date</u>	<u>Facility/Doctor</u>
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

<u>Medicine</u>	<u>Dose</u>	<u>Frequency</u>	<u>For What Illness?</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DO YOU CURRENTLY TAKE: HERBAL SUPPLEMENTS, SUCH AS GINGKOBA OR ST. JOHNS WORT OR ASPIRIN PRODUCTS?  YES  NO

If yes, please list \_\_\_\_\_

**SOCIAL HISTORY:**

Do you smoke?  YES  NO If yes, how much? \_\_\_\_\_

Do you drink alcohol?  YES  NO If yes, how much? \_\_\_\_\_

Previous steroid use?  YES  NO If yes, how much? \_\_\_\_\_

<u>FAMILY HISTORY:</u>	<u>Age</u>	<u>Diseases/Conditions</u>	<u>If Deceased, Cause of Death</u>
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FATHER	_____	_____	_____
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MOTHER	_____	_____	_____
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SIBLINGS	_____	_____	_____
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SPOUSE	_____	_____	_____
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CHILDREN	_____	_____	_____
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# REVIEW OF SYSTEMS

PATIENT NAME \_\_\_\_\_

Please check (√) "yes or "no" to each problem on the list below:

## CONSTITUTIONAL

- No  Yes Good general health lately
- No  Yes Recent weight change
- No  Yes Decreased appetite
- No  Yes Fevers/night sweats
- No  Yes Fatigue/weakness
- No  Yes Headaches

## EYES

- No  Yes Change in vision
- No  Yes Eye disease or injury

## EARS/NOSE/THROAT/MOUTH

- No  Yes Difficult hearing/ringing in ears
- No  Yes Problems with teeth/gums

## CARDIOVASCULAR

- No  Yes Heart trouble
- No  Yes Chest pain or angina pectoris
- No  Yes Palpitation
- No  Yes Shortness of breath with walking or lying flat
- No  Yes Swelling of feet, ankles, or hands
- No  Yes High blood pressure

## CHEST/BREAST

- No  Yes Breast lump
- No  Yes Breast pain
- No  Yes Nipple discharge

## RESPIRATORY

- No  Yes Cough/wheeze
- No  Yes Difficulty breathing

## GASTROINTESTINAL

- No  Yes 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 Rectal bleeding or blood in stool
- No  Yes Abdominal pain
- No  Yes Ulcer (stomach)

## GENITOURINARY

- No  Yes Kidney disease

## MUSCULOSKELETAL

- No  Yes Muscle/joint pain

## SKIN

- No  Yes Rash/mole change
- No  Yes Rash or itching
- No  Yes Change in skin color
- No  Yes Change in hair or nails
- No  Yes Varicose veins

## NEUROLOGICAL

- No  Yes Headaches
- No  Yes Dizziness/light-headedness
- No  Yes Numbness
- No  Yes Memory loss
- No  Yes Loss of coordination

## BLOOD/LYMPHATIC

- No  Yes Slow to heal after cuts
- No  Yes Bleeding or bruising tendency
- No  Yes Anemia
- No  Yes Blood clots
- No  Yes Blood transfusion
- No  Yes Enlarged glands

## ALLERGIC/IMMUNOLOGIC

- No  Yes HIV

History of skin reaction or other adverse reaction to:

- No  Yes Penicillin or other antibiotics
- No  Yes Morphine, Demerol, or other narcotics
- No  Yes Other drugs/medications

## ENDOCRINE

- No  Yes Glandular or hormone problem
- No  Yes Thyroid disease
- No  Yes Diabetes (insulin or non insulin - circle one)
- No  Yes Excessive thirst or urination

## PSYCHIATRIC

- No  Yes Memory loss or confusion
- No  Yes Problems with sleep

## OTHER

- No  Yes Previous anesthesia problems
- No  Yes Other \_\_\_\_\_

FOR PHYSICIAN USE ONLY - DO NOT WRITE IN THIS BOX

Physician reviewed by: \_\_\_\_\_ Date \_\_\_\_\_

Updated / Reviewed: Date \_\_\_\_\_ Date \_\_\_\_\_