

## Comprehensive Patient History Form

Patient Name: \_\_\_\_\_  
Last First Middle Initial

Phone: \_\_\_\_\_

Describe your main problem \_\_\_\_\_

When did this problem start? \_\_\_\_\_

What makes this problem worse or better? \_\_\_\_\_

\_\_\_\_\_

List previous surgeries.

When?


Other hospitalizations:


**Have you ever had the following?**

Diabetes.....	yes	no
Kidney disease.....	yes	no
Hypertension.....	yes	no
Cancer.....	yes	no
Stroke.....	yes	no
Heart trouble.....	yes	no
Arthritis/gout.....	yes	no
Convulsions.....	yes	no
Bleeding tendency.....	yes	no
Acute infections.....	yes	no
Hereditary defects.....	yes	no

**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 \_\_\_\_

Number of years of smoking \_\_\_\_\_

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

Excessive exposure at home or work to:    Fumes    Dust    Solvents    Other \_\_\_\_\_

**Family Medical History**

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

**PLEASE ANSWER ALL QUESTIONS**

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Have you had any of the following during the past three months?**

**CONSTITUTIONAL**

Good general health lately..... No Yes  
 Recent weight loss..... No Yes  
 Fever..... No Yes  
 Fatigue..... No Yes

**EYES**

Eye disease or injury..... No Yes  
 Blurred or double vision..... No Yes  
 Temporary loss of vision..... No Yes

**ENT**

Hearing loss..... No Yes  
 Ringing in the ears..... No Yes  
 Earaches or drainage..... No Yes  
 Sinus problems..... No Yes  
 Nosebleeds..... 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 heartbeat 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  
 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

**GENTOURINARY**

Frequent urination..... No Yes  
 Burning or painful urination..... No Yes  
 Blood in urine..... No Yes  
 Change in force of stream or straining when urinating..... No Yes  
 Incontinence or dribbling..... No Yes  
 Kidney stones..... No Yes  
 Sexual difficulty..... No Yes  
 Male – testicle pain..... No Yes  
 Female – pain with periods..... No Yes  
 Female – irregular periods..... No Yes  
 Female – vaginal discharge..... No Yes  
 Female – # pregnancies \_\_\_\_\_ # miscarriages \_\_\_\_\_

**MUSCULOSKELETAL**

Joint pain..... 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

**SKIN**

Rash or itching..... 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  
 Lightheaded or dizzy..... No Yes  
 Convulsions or seizures..... No Yes  
 Numbness or tingling sensations..... No Yes  
 Tremors..... No Yes  
 Paralysis..... No Yes  
 Stroke..... No Yes  
 Head injury..... No Yes

**PSYCHIATRIC**

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

**ENDOCRINE**

Thyroid disease..... No Yes  
 Diabetes..... No Yes  
 Excessive thirst or urination..... No Yes  
 Heat or cold intolerance..... No Yes

**HEMATOLOGIC/LYMPHATIC**

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

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

Physician Signature: \_\_\_\_\_

## MEDICATION LIST

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name and location of your Pharmacy: \_\_\_\_\_

*Please include: All prescription medications, herbal supplements, over-the-counter medications, inhalers, topicals, and eye drops.*

Name of medication	Dose/Strength	Route (by mouth/shot)	How often do you take it	Last dose taken/Date
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				

### ALLERGIES/SENSITIVITIES

### WHAT WAS YOUR REACTION?
