

Date: _____

Patient Name: _____

Date of Birth: _____

Physician Sign/Date: _____

PATIENT MEDICAL HISTORY

Last Name	First	Middle	Birth Date	Age	Sex
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Address	City	State/Zip	Home Phone	Work Phone
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Person to Notify	Relationship	Address	Phone Number
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Primary Care Physician	Address	Phone Number
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Briefly describe your present symptoms: _____

PAST MEDICAL HISTORY: (please attach additional sheets if needed)

Operations: _____

Medical Problems or Hospitalizations: _____

Allergies: _____

Current Medications and Doses: _____

SOCIAL HISTORY:

Martial Status: (please circle) Single Married Divorced Widowed

Number of Children: _____ Occupation: _____

Personal Habits: (please circle)

Do you currently smoke? YES NO If yes, how many years did you smoke? _____

If yes, how many packs a day? _____ If you previously smoked, when did you quit? _____

Do you drink alcohol? YES NO If yes, how many drinks/day? _____

FAMILY HISTORY: Has any blood relative had any of the following? (please circle)

Heart Attack	YES	NO	Diabetes	YES	NO
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Stroke	YES	NO	Kidney Disease	YES	NO
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High Blood Pressure	YES	NO	Cancer	YES	NO
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Are there any other medical problems that run in your family? _____

Instructions: Staple to initial consult note

Revised: April 2009

CONFIDENTIAL RECORD: Information contained here will not be released except when you have authorized us to do so.

REVIEW OF SYSTEMS: Have you had any of the following? (please circle)

Constitutional

Weight change in the past year	YES	NO
Recent Fever/Chills	YES	NO
Fatigue	YES	NO

Eyes

Cataracts	YES	NO
Loss of Vision	YES	NO

Ears, Nose, Throat

Hearing Loss	YES	NO
Ringing in ears	YES	NO
Nosebleeds	YES	NO
Hoarseness	YES	NO

Cardiovascular

Chest Pain	YES	NO
High Blood Pressure	YES	NO
Morning Headaches	YES	NO
Palpitations	YES	NO
Loss of consciousness (passed out)	YES	NO
Murmur	YES	NO
Swelling in ankles	YES	NO
Leg cramps when walking	YES	NO
History of rheumatic fever, scarlet fever, diphtheria, syphilis	YES	NO

Respiratory

Shortness of breath at rest	YES	NO
Shortness of breath on exertion	YES	NO
Do you have to sleep propped up?	YES	NO
Do you wake gasping for air?	YES	NO
Emphysema	YES	NO
Asthma	YES	NO
Chronic cough/sputum production	YES	NO

Musculoskeletal

Arthritis	YES	NO
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Gastrointestinal

Abdominal pain	YES	NO
Indigestion	YES	NO
Nausea	YES	NO
Gallstones	YES	NO
Change in bowel habits	YES	NO
Dark black stools/ blood in stools	YES	NO

Genital Urinary

Kidney Stones	YES	NO
Blood in urine	YES	NO
Waking at night to urinate	YES	NO

Skin/Breast

Rashes	YES	NO
Breast lump	YES	NO

Neurologic

Stroke	YES	NO
Seizures	YES	NO
Numbness/inability to move/speak	YES	NO
Vertigo (dizziness)	YES	NO

Psychiatric

Depression	YES	NO
Psychiatric Disorder	YES	NO

Heme/Lymph

Anemia	YES	NO
Bleeding tendency	YES	NO

Endocrine/Metabolic

Diabetes	YES	NO
Thyroid disease	YES	NO
High Cholesterol	YES	NO
Hormone problems	YES	NO

Immunologic

Immune system problems	YES	NO
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