

LAST NAME _____ FIRST NAME _____ TODAY'S DATE _____ TIME _____

DATE OF BIRTH _____ REFERRING DOCTOR _____ LAST EXAM DATE _____

CHIEF COMPLAINT: What is the main reason for your visit today? (Describe your problem in detail including duration)

HISTORY OF PRESENT ILLNESS: ♦ Note: Please answer the following questions in detail!

1.Location of the problem: □ Abdomen □ Back □ Leg □ Other _____ □ Front □ Back

2.Quality: Is the problem Constant or Variable?

□ Dull, then Sharp □ Very Sharp then leaves □ Always there □ Other _____

3.Severity: On a Scale of 1-10, with 10 being the most severe, Check the number that best describes the severity of problem?

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

4.Duration: When did you first notice the problem?

□ Two days ago □ 2 weeks ago □ 2 months ago □ Other _____

5.Timing: How long does the problem last? □ 30mins □ 1 hour □ It is always there □ Other _____

6.Context: Does the problem interfere with your normal functions?

□ Yes □ No If Yes, please explain _____

7.Modifying Factors: Does anything help or make the problem worse?

□ Moving around □ Standing up □ Lying on my side □ Other _____

8.Associated Signs & Symptoms: Is there anything else occurring at the same time? □ Yes □ No. If Yes please explain below:

□ Nausea □ Rash □ Headaches □ Other _____

PAST, FAMILY & SOCIAL HISTORY

♦ Medications: Please list all medications you are currently taking.

Table with 6 columns: DRUG NAMES, DOSE, START DATE, DRUG NAMES, DOSE, START DATE

PAST MEDICAL HISTORY: ♦ List any personal past illnesses and or Surgeries and when they occurred.

Table with 4 columns: ILLNESS OR SURGERY, DATE, ILLNESS OR SURGERY, DATE

♦ ALLERGIES: Do you have any allergies to medicines or food ? □ No □ Yes. IF YES, PLEASE LIST BELOW:

□ PENICILLIN. □ SULFA. □ CIPRO. □ MACRODANTIN. □ OTHER: _____

FAMILY HISTORY: ♦ List all serious illnesses in your Immediate family.

Table with 3 columns: YES NO RELATION, YES NO RELATION, YES NO RELATION/ TYPE OF CANCER

♦ Do you Drink Alcohol? □ No □ Yes. What do you drink? _____ How much? _____ Quit Date: _____

♦ Do you Smoke Cigarettes? □ No □ Yes. How much? _____ Quit date: _____ How long were you smoking? _____

PHYSICIAN USE ONLY:(Comment/Notes) _____

◆ Do you now have or have you had any of the following problems? Please explain any "Yes" answer

CONSTITUTIONAL SYMPTOMS:

1.Fever N Y 2.Chills N Y 3.Weight loss N Y 4.Headaches N Y 5.Other _____

EYES:

1.Blurred Vision N Y 2.Double Vision N Y 3.Pain N Y 4.Other _____

EARS/NOSE/MOUTH/THROAT:

1.Hearing loss N Y 2.Hay fever N Y 3.Loss of Smell N Y 4.Sinus Problem N Y 5.Other _____

CARDIOVASCULAR:

1.Chest Pains N Y 2.Irregular Heart Beat N Y 3.Varicose Veins N Y 4.Other _____

RESPIRATORY:

1.Wheezing N Y 2.Frequent Cough N Y 3.Shortness of Breath N Y 4.Other _____

GASTROINTESTINAL:

1.Abdominal Pain N Y 2.Nausea/Vomiting N Y 3.Constipation N Y 4.Other _____

GENITOURINARY:

1.Urine Retention N Y 2.Painful Urination N Y 3.Blood in Urine N Y 4.Other _____

MUSCULSKELETAL:

1.Joint Pain N Y 2.Neck Pain N Y 3.Back Pain N Y 4.Back Injury N Y 5.Other _____

INTEGUMENTARY:

1.Skin Rash N Y 2.Persistant Itch N Y 3.Boils N Y 4.Other _____

NEUROLOGICAL:

1.Tremors N Y 2.Dizziness N Y 3.Numbness/Tingling N Y 4. Other _____

PSYCHIATRIC:

1.Depression N Y 2.Anxiety N Y 3.Suicidal Tendencies N Y 4.Other _____

ENDOCRINE:

1.Excessive Thirst N Y 2.Too Hot/Cold N Y 3.Tired/sluggish N Y 4.Other _____

HEMATOLOGIC/LYMPHATIC:

1.Swollen Glands N Y 2.Blood clotting Problem N Y 3.Anemia N Y 4.Other _____

ALLERGIC/IMMUNOLOGIC:

1.Hay Fever N Y 2.Other _____

PHYSICIAN USE ONLY: (Comments/Notes) _____

