

LAST NAME _____ FIRST NAME _____ TODAY'S DATE _____

DATE OF BIRTH _____ REFERRING DOCTOR _____ LAST EXAM DATE _____

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

History of Present Illness

◆**Note:** Please answer the following questions

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, Circle the number that best describes the 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 1 month 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.

DRUG NAME	DOSE	FREQUENCY	START DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

◆**List any personal past Illnesses and or Surgeries and when they occurred.**

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:

◆**List all serious Illnesses in your Immediate family.**

	YES	NO	RELATION		YES	NO	RELATION		YES	NO	RELATION
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

◆**Do you Drink Alcohol?** No Yes. If yes, what do you drink? _____ How much? _____

◆**Do you Smoke Cigarettes?** No Yes. If yes, how much? _____ 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 _____

MUSCULOSKELETAL:

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) _____

NEW PATIENT REVIEW OF SYSTEMS (0-1 = 1 or 2; 2-9 = 3; 10+ = 4 or 5.)

PHYSICIAN SIGNATURE OR INITIALS _____

EST PATIENT REVIEW OF SYSTEMS (0 = 1 or 2; PERT=3; 2-9 = 4; 10+ = 5)

DATE: _____