

PATIENT HISTORY

Name _____ Phone _____ Birth Date _____ Age _____ Sex _____

Who requested that you see our physicians? _____ Address _____

Internist or Family Physician: _____ Address _____

What is your major problem or complaint? _____

When did your problem start? _____

Was there a specific injury? _____ If so, what happened? _____

Do you consider it work related? _____ How? _____

Have you seen other doctors for this problem? _____ Who? _____

PAST MEDICAL HISTORY (check all present):

- Diabetes
- Hypertension
- Hepatitis/liver disease
- Thyroid disease
- Other (explain) _____
- Heart trouble
- Cancer
- AIDS or HIV
- Kidney disease
- Stroke
- Serious infection
- Psychiatric illness
- COPD/asthma
- Arthritis/gout
- Blood clots
- Ulcer/stomach prob.
- Head injury
- Convulsions
- Hereditary defects
- Trauma
- Anemia

Previous surgeries (include year): 1) _____

2) _____ 3) _____

4) _____ 5) _____

Systems review (check all present):

- Rash/unusual mole
- Night sweats
- Fever
- Fatigue
- Weight change
- Other: _____
- Easy bruising
- Sinus problems
- Bleeding tendency
- Bowel problems
- Bladder difficulties
- Chest pain
- Cold extremities
- Shortness of breath
- Joint pain
- Back pain
- Headaches
- Dizziness
- Tremors
- Difficulty walking
- Sleeping problems
- Paralysis
- Memory loss
- Hearing Loss
- Visual change
- Numbness/tingling

Explain: _____

Medications you are taking (include dose, over the counter drugs, and vitamins): _____

Allergies: _____

Diseases that run in the family (include deceased family members): _____

Do you smoke now? _____ Packs per day? _____ How long? _____ Have you in the past? _____

When did you quit? _____ Do you drink alcohol excessively? _____ Do you use drugs? _____ Have you been treated for substance abuse? _____

Marital Status _____ Number of children _____ Do you have a healthcare directive or power of attorney? _____

Occupation _____ Height _____ Weight _____