Patient History/Problem Summary

reivised 1/12

Last Name	First	Middle Initial
Date of Birth Age	Home Phone ( )	Business Phone
Home Address, City, State, Zip		
Primary Care Physician	Referred by	Reason for Visit
Emergency contact name and phone number		

Patient Medical History (please check if you ever had or now have)

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Trouble
- ☐ Arthritis
- ☐ Gout
- ☐ Glaucoma
- ☐ Cancer
  What type? _____
- ☐ Bleeding Tendency
- ☐ Sexual Disease
- ☐ Thyroid Problems
- ☐ Osteoporosis
- ☐ Disability
- ☐ Ulcer(s)
- ☐ Severe Back Pain
- ☐ Pulmonary Tuberculosis
- ☐ Asthma
- ☐ Hay Fever
- ☐ Convulsions/Seizures
- ☐ Serious Infections
- ☐ Pneumonia
- ☐ Blood Transfusion
- ☐ None of these

Immunizations/Shots:

- ☐ Hepititus B Year: _____
- ☐ Influenza Year: _____
- ☐ Tetanus Year: _____
- ☐ Pneumovax Year: _____

List all surgeries you have had:

1) 3)
2) 4)

List all other hospitalizations you have had beginning with the most recent:

Year	Reason	Physician

Current Medications

Please List All (e.g. sprays, inhalers, ointments, drops, pills, injections and dosage). Include all herbal, alternative and over-the-counter medications.

1) 8)
2) 9)
3) 10)
4) 11)
5) 12)
6) 13)
7) 14)

Medication Allergies:

Family History: (Choose from list of dieases listed above)

	Age	Diseases	If deceased, cause of death
Father			
Mother			
Brother/Sister			
Brother/Sister			
Son/Daughter			
Son/Daughter			

Occupation: _____

Social History

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ Widowed

Years of School Completed: _____

Ethnic Origin: _____

Current use of tobacco: ☐ Never ☐ Current User ☐ Used to Quit date: _____ Packs per day: _____

Current use of alcohol: ☐ Never ☐ Occasionaly ☐ Used to Amount _____

Have you ever used these drugs?

☐ Marijuana ☐ Cocaine ☐ Heroin ☐ IV Drugs ☐ Other _____

Do you currently use illegal drugs? ☐ Yes ☐ No

Patient Past History

Please place a check in the box if you have had the following in the past.

Integumentary
- ☐ Skin Lesion Biopsy
- ☐ Have you been hospitalized in the last 8 weeks? (MRSA)

Eye
- ☐ Eye disease or injury

Ears-Nose-Throat
- ☐ Chronic sinus problems
- ☐ Problems with hearing

Psychiatric
- ☐ Memory loss or confusion
- ☐ Depression
- ☐ Insomnia

Cardiovascular
- ☐ Chest pain or angina
- ☐ Palpitations
- ☐ Shortness of breath with walking
- ☐ Fast heartbeat
- ☐ Slow heartbeat

Pulmonary
- ☐ Had any chest illness within the past three (3) years which has kept you from your usual activities?
- ☐ Whooping cough
- ☐ Has a positive PPD

Gastrointestinal
- ☐ Frequent diarrhea
- ☐ Rectal bleeding
- ☐ Blood in stool
- ☐ Peptic ulcer (stomach or duodenal)
- ☐ Hepatitis

Endocrine
- ☐ Diabetes (insulin or non insulin)

Hematologic/Lymphatic
- ☐ Bleeding or bruising tendency
- ☐ Slow to heal after cuts
- ☐ Anemia

Neurological
- ☐ Frequent or recurring headaches
- ☐ Tremors
- ☐ Paralysis
- ☐ Stroke
- ☐ Head injury
- ☐ Loss of consciousness

Genitourinary
- ☐ Kidney stones

Musculoskeletal
- ☐ Joint stiffness

Allergic/Immunnologic

History of skin or adverse reaction to:
- ☐ Penicillin or other antibiotics
- ☐ Morphine, Demerol
- ☐ Other narcotics
- ☐ Novocain
- ☐ Aspirin
- ☐ Tetanus antitoxin/other serums
- ☐ Iodine, merthiolate or antiseptic

Other drugs/medications (list allergies)

_____

_____

Known food allergies

_____

_____

Environmental allergies (list):

_____

_____

Female
- ☐ Estrogen replacement
- ☐ Abnormal PAP
- ☐ Breast lump

When was your last...

PSA_____
Mamogram_____
PAP_____
Colonoscopy_____

Please check box if you are now experiencing any of these symptoms.

Constitutional Systems
- ☐ Poor general health lately
- ☐ Recent weight gain - Amt_____
- ☐ Recent weight loss - Amt_____
- ☐ Decreased appetite
- ☐ Fever
- ☐ Fatigue/weakness
- ☐ Daytime sleepiness
- ☐ Night sweats
- ☐ Snore

Eye
- ☐ Glasses/contact lenses
- ☐ Vision problems

Ears-Nose-Throat
- ☐ Runny Nose
- ☐ Nose Bleeds
- ☐ Mouth sore
- ☐ Sore throat
- ☐ Voice change
- ☐ Swollen glands
- ☐ Problems with hearing
- ☐ Trouble breathing through nose

Psychiatric
- ☐ Memory loss or confusion
- ☐ Nervousness
- ☐ Depression
- ☐ Insomnia

Hematologic/Lymphatic
- ☐ Phlebitis

Allergic/Immunnologic
- ☐ Itchy or watery eyes
- ☐ Postnasal drip
- ☐ Sneezing

Integumentary
- ☐ Rash or itching
- ☐ Change in mole or other lesion

Genitourinary
- ☐ Problems with urination
- ☐ Sexual difficulty
- ☐ Blood in urine
- ☐ Pain on urination
- ☐ Kidney infection
- ☐ Dark urine

Musculoskeletal
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Muscle pain
- ☐ Muscle cramps
- ☐ Difficulty/pain walking

Male
- ☐ Testicle pain or lump
- ☐ Prostate problems
- ☐ Trouble urinating
- ☐ Frequent urination
- ☐ Dribbling after urinating

Female
- ☐ Last menstrual period _____
- ☐ Age onset of menopause_____
- ☐ Irregular periods
- ☐ Breast lump
- ☐ Breast discharge
- ☐ Heavy vaginal bleeding

Cardiovascular
- ☐ Chest pain or angina
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Shortness of breath with lying flat
- ☐ Swelling of feet or ankles
- ☐ Swelling of hands
- ☐ Fast heartbeat
- ☐ Slow heartbeat

Respiratory
- ☐ Do you cough?

  If so, When?
  - ☐ In the winter
  - ☐ First thing in morning
  - ☐ During the day
  - ☐ At night

  Is cough productive?_____

  What color is sputum?_____
- ☐ Shortness of breath

  If so, When?
  - ☐ Walking up a slight hill
  - ☐ On level ground
- ☐ Asthma or wheezing
- ☐ Cough up blood

Endocrine
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive thirst or urination

Neurological
- ☐ Frequent or recurring headaches
- ☐ Lightheaded or dizzy
- ☐ Convulsions or seizures
- ☐ Numbness or tingling sensation of arms/legs
- ☐ Tremors
- ☐ Paralysis or weakness
- ☐ Blurred vision
- ☐ Double vision

Are there any other symptoms not listed that you are experiencing?

_____

_____

_____

Review by _____ Date:_____

Patient History

CHIEF COMPLAINT

In your own words, briefly describe the problem(s) responsible of your visit.

_____

_____

_____

_____

HISTORY OF PRESENT ILLNESS

Briefly describe the following as it relates to the symptoms of your current problem(s).

How long: _____

Severity (circle one) Mild Moderate Severe Extreme

When during day, week, etc:_____

What is it related to:_____

What makes it better or worse:_____

_____

Associated problems:_____

Treatments & medications:_____

_____

Your physician's comments:_____

_____

_____

FAMILY PSYCHIATRIC HISTORY

List any significant illness(es) which have occurred in your family. Please include any mental illnesses like depression, anxiety, manic-depression, schizophrenia or dementia Alzheimer's.

ILLNESS	RELATIVE
1. _____	_____
2. _____	_____
3. _____	_____

SOCIAL HISTORY

A. Family of Origin

1. Mother - age (if living)_____ Deceased (age at death)_____
2. Father - age (if living)_____ Deceased (age at death)_____
3. Siblings - (ages and your place in thr order of birth): _____

   _____
4. Quality of relationships in family of origin:
   a. Mother _____
   b. Father_____
   c. Siblings_____

   _____
5. Childhood illnesses or abuse (briefly describe, if any)

_____

_____

_____

_____

Patient History

MARTIAL/CURRENT FAMILY HISTORY

1) ☐ Currently married ☐ Never married ☐ Widow(er) ☑ Divorced
☐ Married more than once (briefly describe length of marriage(s) and reasons for divorce(s).

2) Spouse (age, occupation and quality of current relationship) _____

3) Children (list by age, give health status and quality of your relationship)

EDUCATIONAL /OCCUPATIONAL HISTORY

1. School performance (circle one): Below Average Average Above Average Superior
2. Military service: ☐ No ☐ Yes (branch, years, rank)_____
3. Past jobs (worked 6 months or more). List in chronological order.
4. Current occupation (job title and description, place of employment, years worked, level of satisfaction._____
5. Disability (if any, describe nature of injury, date, circumstances, lawsuit status, disability benefits)_____
6. Retirement (year retired, quality of retirement)_____

LIFESTYLE

1) Current Diet: ☐ Well-balanced ☐ Vegetarian ☐ High fat
☐ Other (describe):_____

2) Caffeine (cups of coffee or caffeinated beverages): ☐ None ☐ 1-3/day ☐ 3-5/day
☐ More than 5/day (specifiy)_____

3) Exercise: ☐ None ☐ Occasional ☐ Moderate ☐ Vigorous
Describe: _____

EXPECTATIONS AND GOALS

Briefly describe what you expect to happen as a result of your assessment and treatment. Please be as specific as possible._____