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PATIENT HISTORY FORM

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GENERAL INFORMATION

Patient's Name__________ Age______ Sex______ Date__________

Chief Complaints (Why you came to see the doctor today. List each problem and when it stated)

1) __________
2) __________
3) __________

Associated Symptoms (Problems which you think are related to your chief complaints)

1) __________
2) __________
3) __________

PAST MEDICAL HISTORY

Review of Systems (Problems you currently have or have been diagnosed with in the past) Please mark all boxes (No/Yes) and add details in blanks.

1) Constitutional

No Yes
- ❑ ❑ Weight Loss__________
- ❑ ❑ Weight Gain__________
- ❑ ❑ Chronic Fever__________
- ❑ ❑ Anesthetic Reaction__________
- ❑ ❑ Birth Complications__________
- ❑ ❑ Childhood Illness__________

2) Eyes

No Yes
- ❑ ❑ Visual Problems__________
- ❑ ❑ Double Vision__________

3) Head/Ear Nose & Throat

No Yes
- ❑ ❑ Ear Infections__________
- ❑ ❑ Ear Pain__________
- ❑ ❑ Hearing Loss__________
- ❑ ❑ Ringing in Ears__________
- ❑ ❑ Ear Drainage__________
- ❑ ❑ Dizziness__________
- ❑ ❑ Sinus Infections__________
- ❑ ❑ Smell & Taste Disorder__________
- ❑ ❑ Nasal Obstruction__________
- ❑ ❑ Nasal Polyps__________
- ❑ ❑ Nose Bleeds__________
- ❑ ❑ Dental Problems__________
- ❑ ❑ TMJ Syndrome__________
- ❑ ❑ Hoarseness__________
- ❑ ❑ Swallowing Problems__________
- ❑ ❑ Neck Mass/Swelling__________
- ❑ ❑ Snoring__________
- ❑ ❑ Apnea__________
- ❑ ❑ Other__________

4) Cardiovascular

No Yes
- ❑ ❑ Rheumatic Fever__________
- ❑ ❑ Heart Problems__________
- ❑ ❑ Strokes__________
- ❑ ❑ TIA's__________
- ❑ ❑ Irregular Heart Beat__________
- ❑ ❑ High Blood Pressure__________
- ❑ ❑ Chest Pain__________

5) Respiratory

No Yes
- ❑ ❑ Chronic Cough__________
- ❑ ❑ COPD__________
- ❑ ❑ Asthma__________
- ❑ ❑ Shortness of Breath__________

6) Gastrointestinal

No Yes
- ❑ ❑ Stomach Ulcers__________
- ❑ ❑ Heartburn/Acid Reflux__________
- ❑ ❑ Hepatitis__________
- ❑ ❑ Hiatal Hernia__________
- ❑ ❑ Food Sensitivity__________

7) Genitourinary

No Yes
- ❑ ❑ Kidney Problems__________
- ❑ ❑ Kidney Infection__________

8) Musculoskeletal

No Yes
- ❑ ❑ Muscle / Joint Pain__________
- ❑ ❑ Neck Pain__________
- ❑ ❑ Back Pain__________

9) Integument

No Yes
- ❑ ❑ Skin Problems__________
- ❑ ❑ Skin Lesion__________
- ❑ ❑ MRSA__________

10) Neurologic

No Yes
- ❑ ❑ Head Injury__________
- ❑ ❑ Seizures__________
- ❑ ❑ Headaches__________
- ❑ ❑ Loss of Consciousness__________

11) Psychiatric

No Yes
- ❑ ❑ Emotional Disorder__________
- ❑ ❑ Attention Deficit Disorder__________
- ❑ ❑ PTSD__________

12) Endocrine

No Yes
- ❑ ❑ Diabetes__________
- ❑ ❑ Thyroid Disease__________

13) Hematologic – Lymphatic

No Yes
- ❑ ❑ Easy Bleeding / Bruising__________
- ❑ ❑ Cancer__________
- ❑ ❑ Enlarged Lymph Nodes__________
- ❑ ❑ Blood Disease__________

14) Allergic – Immunologic

No Yes
- ❑ ❑ Allergies__________
- ❑ ❑ Hay Fever__________
- ❑ ❑ Hives__________
- ❑ ❑ AIDS / HIV Positive__________

Medical History (List medical illnesses, chronic conditions, and hospitalizations you have had)

❑ **NO MEDICAL HISTORY**

	Diagnosis	Treatment	Doctor	Date of Diagnosis
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

Surgical History (List any surgeries that you have had)

Have you been told to take antibiotics before surgery or dental work? ❑YES ❑NO

❑ **NO SURGICAL HISTORY**

	Surgery	Doctor	Date of Diagnosis
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Current Medications (List all prescribed medications as well as all "over-the-counter" medications, vitamins, herbals and supplements)

❑ **NOT TAKING ANY MEDICATIONS**

	Name of Drug	Reason Taken	Dose/Duration	Date Started
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

Medication Reactions / Allergies (List each reaction which has occurred)

❑ **NO KNOWN ALLERGIES** **LATEX ALLERGY?** ❑**YES** ❑**NO**

Medication / Substance | Reaction | Date of Occurrence

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________
5) ______________________________
6) ______________________________
7) ______________________________
8) ______________________________
9) ______________________________
10) ______________________________

Family History (Please mark all boxes and add details in blanks regarding health status or cause of death in immediate family)

❑ Heart Disease______	❑ Anesthetic Reaction______	❑ Hereditary Diseases______
❑ High Blood Pressure______	❑ Deafness______	❑ Cancer______
❑ Diabetes______	❑ Allergy______	❑ Other______
❑ Stroke______	❑ Hay Fever______	❑ ______
❑ Bleeding Disorder______	❑ Asthma______	❑ ______
______	❑ Thyroid Disorder______	❑ ______
______	❑ Kidney Disease______	❑ ______

Social History (List all that apply)

Chemical / Mold Exposure? ❑YES ❑NO

Type | Duration | When Stopped

1) Tobacco use______________________________
2) Alcohol use______________________________
3) Street Drug Use______________________________
4) Current Employment______________________________

Patient Signature______________________________ Date______________