



# PATIENT HISTORY FORM

## GENERAL INFORMATION

PATIENT'S NAME \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ DATE \_\_\_\_\_  
 PARENT \_\_\_\_\_ PHONE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
 REFERRED BY \_\_\_\_\_

## MEDICAL INFORMATION

### A. CHIEF COMPLAINTS (Why you are here to see the doctor today) - List each complaint and when it started.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### B. GENERAL ALLERGY SYMPTOMS - Check box beside symptoms associated with your allergies:

- |                                                         |                                                          |                                                           |                                               |
|---------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Worse outdoors                 | <input type="checkbox"/> Better outdoors                 | <input type="checkbox"/> Worse on cool evenings           | <input type="checkbox"/> Worse in basement    |
| <input type="checkbox"/> Worse on windy days            | <input type="checkbox"/> Worse indoors                   | <input type="checkbox"/> Worse in low, damp place         | <input type="checkbox"/> Worse near a barn    |
| <input type="checkbox"/> Worse on clear days            | <input type="checkbox"/> Worse 30 minutes after retiring | <input type="checkbox"/> Worse mowing or playing in grass | <input type="checkbox"/> Worse around animals |
| <input type="checkbox"/> Worse outdoors 7 to 11 a.m.    | <input type="checkbox"/> Worse in cold weather           | <input type="checkbox"/> Worse after lights are on 1 hour | Which ones _____                              |
| <input type="checkbox"/> Worse in change of temperature | <input type="checkbox"/> Worse when sweeping             | <input type="checkbox"/> Worse in certain rooms           | Which one _____                               |
| <input type="checkbox"/> Worse in warm or cool air      | <input type="checkbox"/> Worse when dusting              |                                                           |                                               |
| <input type="checkbox"/> Better indoors                 | <input type="checkbox"/> Worse outdoors from 4 to 9 p.m. |                                                           |                                               |

### C. MEDICAL HISTORY

#### 1. What prescription and non-prescription medications do you take?

- |                                               |                                                  |                                          |                                             |                                                |
|-----------------------------------------------|--------------------------------------------------|------------------------------------------|---------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Aspirin              | <input type="checkbox"/> High Blood Pressure Med | <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Thyroid Medication | <input type="checkbox"/> Antihistamines        |
| <input type="checkbox"/> Cortisone (Steroids) | <input type="checkbox"/> Sedatives               | <input type="checkbox"/> Vitamins        | <input type="checkbox"/> Nose Drops/Sprays  | <input type="checkbox"/> Decongestants         |
| <input type="checkbox"/> Diabetes Med         | <input type="checkbox"/> Heart Disease Med       | <input type="checkbox"/> Asthma Med      | <input type="checkbox"/> Hormones           | <input type="checkbox"/> Anticholesterol Drugs |

List names of all medications: \_\_\_\_\_

#### 2. Check the following medical conditions you are experiencing or have experienced in the past:

- |                                                    |                                        |                                        |                                             |                                    |                                       |
|----------------------------------------------------|----------------------------------------|----------------------------------------|---------------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Skin Disease  | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nasal Polyps       | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Thyroid Dysfunction       | <input type="checkbox"/> Sinus Disease | <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Hives     | _____                                 |
| <input type="checkbox"/> Seizures                  | <input type="checkbox"/> Nasal Surgery | <input type="checkbox"/> Asthma        | <input type="checkbox"/> Migraine Headache  | <input type="checkbox"/> Colitis   | _____                                 |
| <input type="checkbox"/> Stomach or Intestinal Dis | <input type="checkbox"/> Bronchitis    | <input type="checkbox"/> Hay Fever     | <input type="checkbox"/> Croup              | <input type="checkbox"/> Diabetes  | _____                                 |

#### SMOKING HABITS:

Cigarettes # \_\_\_\_\_/day Years Smoked \_\_\_\_\_  
 Pipe # \_\_\_\_\_/day Stopped Smoking \_\_\_\_\_  
 Cigars # \_\_\_\_\_/day in \_\_\_\_\_

#### ALCOHOL INTAKE

- Daily  
 Weekly  
 Special Occasions  
 Never

#### ILLICIT DRUG USE

- Marijuana  
 Cocaine  
 Other

#### CHECK THE FOLLOWING THAT APPLY:

- |                                                             |                                       |
|-------------------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Family Problems                    | <input type="checkbox"/> Over-anxious |
| <input type="checkbox"/> School Problems                    | <input type="checkbox"/> Divorced     |
| <input type="checkbox"/> Frequently Absent From School/Work | <input type="checkbox"/> Separated    |

#### 3. List all surgeries and hospitalizations:

| Date  | Type of Surgery | Reason |
|-------|-----------------|--------|
| _____ | _____           | _____  |
| _____ | _____           | _____  |

4. Are you allergic to any medications? \_\_\_\_\_ If yes, please list \_\_\_\_\_

#### 5. List physicians who participate in your care:

| Name  | Address / Phone | Reason |
|-------|-----------------|--------|
| _____ | _____           | _____  |
| _____ | _____           | _____  |

D. FAMILY HISTORY OF MEDICAL PROBLEMS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SYSTEMS REVIEW

A. GENERAL

1. Nose:

- Stuffy
- Runny
- Itching

2. Ears:

- Stopped up feeling
- Itching
- Sore

3. Nasal Blocking:

- Alternating from one side to the other
- Constant
- Night, what time \_\_\_\_\_
- Day, what time \_\_\_\_\_
- After meals, how long \_\_\_\_\_
- Year round
- Seasonal, which \_\_\_\_\_

4. Mouth:

- Roof itch
- Tongue coated
- Ulcerated
- Lips swell
- Throat itch

5. Eyes:

- Water
- Itch
- Swelling
- Burn

6. Cough:

- Year round
- Seasonal
- Daytime
- a.m.  p.m.
- Worse after a cold

7. Itching:

- Eyes
- Ears
- Between Shoulders
- Throat
- Feet
- Hands

Worse In:

- Winter
- Spring
- Summer
- Fall

8. Sneezing:

- Year round
- Seasonal
- In early a.m.
- At meal time
- 30 minutes after eating
- Smoky places
- Dust

9. General Symptoms:

- Pain, where \_\_\_\_\_
- Nose bleeds
- Weight loss
- Tire out easily
- Sore throats often
- Cannot sleep
- Nightsweats
- Temperature
- Cold frequently

B. STOMACH AND INTESTINES

1. Appetite:

Good \_\_\_\_\_ Picky \_\_\_\_\_ Poor \_\_\_\_\_

2. Bowels:

Regular \_\_\_\_\_ Constipated \_\_\_\_\_

3. Stools:

Diarrhea \_\_\_\_\_ Solid or mucus \_\_\_\_\_ Normal \_\_\_\_\_

4. MOUTH:

- Offensive breath
- Swallowing difficulties
- Sores

STOMACH:

- Choking feeling
- Nausea
- Vomiting
- Bloating
- Retasting
- Gas
- Indigestion

RECTUM:

- Irritated
- Raw
- Pain
- Itchy

C. HEART AND ARTERY

1. Labored Breathing

- Day
- Night
- Use pillows
- How many \_\_\_\_\_
- After exercise

2. Weight Loss:

- How much \_\_\_\_\_
- Dieting
- Diet pills

3. Pain in Chest

- From exercise
- Difficulty breathing
- Stationary
- Radiates

4. Swelling

- Legs
- Feet
- Hands
- Eyes

Time of day  a.m.  p.m.

D. NEUROLOGICAL AND SKELETAL

1. Headaches: How long \_\_\_\_\_ Onset \_\_\_\_\_ Regular \_\_\_\_\_ Periodic \_\_\_\_\_ Irregular \_\_\_\_\_

2. Where Does It Hurt? \_\_\_\_\_

3. Cerebral: Ringing noises \_\_\_\_\_ Dizzy \_\_\_\_\_

4. Joint Pains: Which one \_\_\_\_\_ How often \_\_\_\_\_

5. Muscular Pains: Where \_\_\_\_\_

6. Bursitis: Where \_\_\_\_\_

7. Arthritis: Where \_\_\_\_\_

E. SKIN

1. Sores: Kind \_\_\_\_\_

2. Hives: \_\_\_\_\_

3. Rash: What type \_\_\_\_\_ Where \_\_\_\_\_

F. GENITOURINARY

1. Urination

- Painful  Normal
- Delayed  Bed Wetting
- Frequent  Infections
- Prolonged Day \_\_\_\_\_ Night \_\_\_\_\_