



Patient History Form

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released without your authorization.

Today's Date ____/____/____

Date of Last Physical Exam ____/____/____

Last Name _____

First Name _____

M.I. _____

Primary Care Physician _____

Date of Birth ____/____/____

Allergies to Medications _____

Foods _____

CHIEF COMPLAINT: What is your main reason for your visit today?

History of Present Illness : Please answer the following questions

Location of the Problem

Abdomen Back Groin
Other _____

When did you first notice the problem?

____ Days ____ Weeks ____ Months
Other _____

Does anything help or make it worse?

Moving around Standing Up Lying on my side
Other _____

Is anything else occurring at the same time ?

Yes No If yes, please explain
Nausea Rash Headache
Other _____

Is the problem constant or variable?

Dull, then sharp Very sharp, then leaves
Always there
Other _____

How long does the problem last?

____ Minutes ____ Hours
Always there
Other _____

One a scale of 1 – 10 with 10 being the most severe, circle the number that best Describes your pain: 1 2 3 4 5 6 7 8 9 10

Does this problem interfere with your normal function? Yes No

If yes, please explain _____

List Prior Medical Conditions / Surgeries and Year

Medical Conditions / Year

Previous Surgeries / Year

Social History

Married Divorced Widowed (please circle)

Do you smoke? Y N How Much? _____ For how long? _____

Did you ever smoke? Y N When did you quit smoking? _____

Do you drink alcohol? Y N How much? _____

Are you on a special diet? Y N If yes, please explain) _____

Family History Do any of your family (living or deceased) have the following: (please circle all that apply)

Kidney Stones	Breast Cancer	Urinary Tract Infections	Diabetes	Thyroid Disease
Kidney Cancer	Bladder Cancer	Heart Disease	Tuberculosis	Bleeding Disorders
Kidney Disease	Prostate Cancer	High Blood Pressure	Alcoholism	Anesthesia Problems
Testicular Cancer	Lung Problems	Strokes	Other Disease / Cancer _____	

Review of Systems

Do you now or have you had any problems related to the following systems?

Check Yes or No

Constitutional Systems

Fever	Yes	No
Chills	Yes	No
Headache	Yes	No
Other _____		

Ear, Nose and Throat

Ear Infection	Yes	No
Sore Throat	Yes	No
Sinus Problems	Yes	No
Other _____		

Eyes

Blurred Vision	Yes	No
Double Vision	Yes	No
Pain	Yes	No
Other _____		

Respiratory

Wheezing	Yes	No
Frequent Cough	Yes	No
Shortness of Breath	Yes	No
Other _____		

Neurological

Tremors	Yes	No
Dizzy Spells	Yes	No
Numbness/Tingling	Yes	No
Other _____		

Musculoskeletal

Joint Pain	Yes	No
Neck Pain	Yes	No
Back Pain	Yes	No
Other _____		

Gastrointestinal

Abdominal Pain	Yes	No
Nausea/Vomiting	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Blood in Stool	Yes	No
Other _____		

Cardiovascular

Chest Pain	Yes	No
Varicose Veins	Yes	No
Swollen Ankles	Yes	No
Emphysema / COPD	Yes	No
High Blood Pressure	Yes	No
Other _____		

Integumentary

Skin Rash	Yes	No
Boils	Yes	No
Persistent Itch	Yes	No
Other _____		

Psychologic

Are you generally satisfied with your life?	Yes	No
Do you feel severely depressed?	Yes	No
Have you ever considered suicide?	Yes	No
Other _____		

MD Signature: _____

Date: _____

List Current Medications (Please include over the counter items such as Aspirin, Vitamins)

MEDICATION / DOSAGE

MEDICATION / DOSAGE

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DO YOU HAVE TO TAKE ANTIBIOTICS PRIOR TO DENTAL WORK?

Yes No

HAVE YOU EVER HAD A PROBLEM WITH ANESTHESIA?

Yes No