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Welcome to our practice. As a new or re-established patient we need to develop and review your medical history database. In preparation for your office visit, we kindly ask that you fill out this questionnaire to the best of your ability. The form may seem lengthy but should expedite your evaluation and treatment as we seek solutions to your particular problem.

Patient Name: _____

Date: _____

Chief Complaint: _____

History of Present Illness:

- Location _____
(Where is the pain/problem?)
- Severity _____
(How severe is the pain/problem on a scale of 1-5, 5 being the most severe?)
- Timing _____
(Does this pain/problem occur at a specific time?)
- Associated signs/symptoms _____

(What other associated problems have you been having?)

- Quality _____
(Example: normal versus abnormal color, activity, etc.)
- Duration _____
(How long have you had this pain/problem? or When did it start?)
- Context _____
(Where were you at the onset of this pain/problem?)
- Modifying factors _____

(What makes the pain/problem worse or better? Or have you had previous episodes?)

Medical History:

Patient Medical History:

Diabetes	No	Yes
Cancer	No	Yes
Stroke	No	Yes
Heart Trouble	No	Yes
Arthritis/gout	No	Yes
Convulsions	No	Yes
Bleeding Tendency	No	Yes
Acute infections	No	Yes
Venereal Disease	No	Yes
Hereditary Disease	No	Yes

Previous Hospitalizations/Surgeries/Serious Injuries

Date

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

Patient Social History:

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol	Never	Rarely	Moderate	Daily	
Use of Tobacco	Never	Previously, but quit: _____		Current packs/day: _____	
Use of Drugs	Never	Type/Frequency: _____			

Family Medical History:

	Age	Living or Deceased	Significant medical problems
Father	_____	L D	_____
Mother	_____	L D	_____
Siblings	_____	L D	_____
	_____	L D	_____
	_____	L D	_____
Spouse	_____	L D	_____
Children	_____	L D	_____
	_____	L D	_____

REVIEW OF SYSTEMS

CONSTITUTIONAL SYMPTOMS

Good general health lately No Yes
Recent weight change No Yes
Fever No Yes
Fatigue No Yes
Headaches No Yes

EYES

Eye disease or injury No Yes
Wear glasses/contacts No Yes
Blurred or double vision No Yes
Glaucoma ... **Wide Angle / Narrow Angle** No Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing..... No Yes
Earaches or drainage No Yes
Chronic sinus problem or rhinitis No Yes
Nose bleeds No Yes
Mouth sores No Yes
Bleeding gums No Yes
Bad breath or bad taste No Yes
Sore throat or voice change No Yes
Swollen glands in neck No Yes

CARDIOVASCULAR

Heart trouble No Yes
Chest pain or angina pectoris No Yes
Palpitations No Yes
Shortness of breath with walking or lying flat ... No Yes
Swelling of feet, ankles or hands No Yes

RESPIRATORY

Chronic or frequent coughs No Yes
Spitting up blood No Yes
Shortness of breath No Yes
Asthma or wheezing No Yes

GASTROINTESTINAL

Loss of appetite No Yes
Change in bowel movements No Yes
Nausea or vomiting No Yes
Frequent diarrhea No Yes
Painful bowel movements or constipation No Yes
Rectal bleeding or blood in stool No Yes
Abdominal pain No Yes
Peptic ulcer (stomach or duodenal) No Yes

GENITOURINARY

Frequent urination No Yes
Burning or painful irritation No Yes
Blood in urine No Yes
Change in force of strain when urinating No Yes
Incontinence or dribbling No Yes
Kidney stones No Yes
Sexual difficulty No Yes
Male – testicle pain No Yes
Female – pain with periods No Yes
Female – irregular periods No Yes
Female – vaginal discharge No Yes
Female - # of pregnancies _____
Female - # of miscarriages _____
Female – date of last pap smear _____

MUSCULOSKELETAL

Joint pain No Yes
Joint stiffness No Yes
Weakness of muscles or joints No Yes
Muscle pain or cramps No Yes
Back pain No Yes
Cold extremities No Yes
Difficulty in walking No Yes

INTEGUMENTARY (skin and breast)

Rash or itching No Yes
Change in skin color No Yes
Change in hair or nails No Yes
Varicose veins No Yes
Breast pain No Yes
Breast lump No Yes
Breast discharge No Yes
Date of last mammogram _____

NEUROLOGICAL

Frequent or recurring headaches No Yes
Light headedness or dizziness No Yes
Convulsions or seizures No Yes
Numbness or tingling sensations No Yes
Tremors No Yes
Paralysis No Yes
Stroke No Yes
Head injury No Yes

PSYCHIATRIC

Memory loss or confusion No Yes
Nervousness No Yes
Depression No Yes
Insomnia No Yes

ENDOCRINE

Glandular or hormone problem No Yes
Thyroid disease No Yes
Diabetes (insulin or non-insulin – circle one)..... No Yes
Excessive thirst or urination No Yes
Heat or cold intolerance No Yes
Skin becoming drier No Yes
Change in hat or glove size No Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts No Yes
Bleeding or bruising tendency No Yes
Anemia No Yes
Phlebitis No Yes
Past transfusion No Yes
Enlarged glands No Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:
Penicillin No Yes
Morphine, Demerol or other narcotics No Yes
Novocain or other anesthetics No Yes
Aspirin or other pain remedies No Yes
Tetanus antitoxin or other serums No Yes
Iodine, methiolate or other antiseptic No Yes
Other drugs/medications _____
Known food allergies: _____
Environmental allergies: _____

Date: _____