



Patient History

Name _____ Date _____

1. History of Present Illness

What is the problem you are being seen for today? _____

Location _____ (Where is the pain?)

Severity _____ (How severe is the pain?)

Duration _____ (How long have you had the pain?)

Associated signs/symptoms _____

2. Please list all prior hospitalizations and surgeries:

<u>Year</u>	<u>Operation/Illness</u>	<u>Year</u>	<u>Operation/Illness</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. Please list any allergies to medicines, foods, x-ray Dyes, environmental items, adhesive tapes:

Example: Penicillin causes a rash, eggs cause hives, pollen causes sneezing.

Known allergies: Yes No

<u>Allergy</u>	<u>Reaction</u>
_____	_____
_____	_____
_____	_____
_____	_____

4. List all medications you are now taking or have taken in the last two weeks:

<u>Medicine</u>	<u>Dose/Times</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Height _____ Weight _____

6. What conditions are you currently being treated for?

Condition

How long have you had this condition?

_____	_____
_____	_____
_____	_____
_____	_____

7. Review of System. Have you ever experienced:

- | | | |
|--|------------------------------|-----------------------------|
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thyroid Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anxiety or nervousness for which you have been treated | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Muscular pain in the legs or buttocks while walking | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Strokes or temporary lapse in memory or control of extremities | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hear attack or chest pain during activities | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart rhythm disturbances | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Congestive hear failure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart catheterization or stress testing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Frequent nighttime awakening due to shortness of breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shortness of breath with mild exertion | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hernia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Need to sleep propped up on 2 or more pillows | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you wear dentures | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| History of peptic ulcers or intestinal bleeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Urinary difficulties or loss of continence | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Frequent swelling of lower extremities | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| History of blood clots | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| History of unusual of frequent infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Excessive surgical bleeding, bruising or nose bleeds | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is there any possibility that you are pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

8. Do you have any known family history of:

- | | | |
|------------------------------|------------------------------|-----------------------------|
| Difficulties with anesthesia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Attack or angina | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood clots | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Tendencies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tuberculosis (TB) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

9. Do you use any special breathing equipment at home?

If yes, Nebulizer Inhalers Oxygen Breathing Treatments

Yes No

10. Do you have a history of TB?

Have you been exposed to TB?

Date of exposure _____

History of skin test positive negative unknown

Date of skin test (approx.) _____

Date of last vaccinations (if known): Influenza (Flu) _____ Hepatitis _____

Tetanus _____ Pneumonia _____ Other _____

Yes No

Yes No

11. Recent history of:

- Productive cough Lethargy/Weakness Night Sweats
 Weight loss Coughing up blood Fever Loss of Appetite

12. Have you ever had difficulties with anesthesia? Yes No

If yes, what difficulties _____

13. Do you use tobacco? No Pipe Cigar Chew

Quit Date quit _____

Do you smoke? Yes No

How many packs per day? _____ For how many years? _____

14. Do you drink alcohol? Yes No

If yes: How much _____ How often? _____

Date of last drink: _____

15. Do you use street/recreational drugs? Yes No In a recovery program

What kind? _____

Date last used _____

16. Dietary/Nutritional

Do you have any special diet, food or cultural preferences/requirements?

Regular Soft Kosher

Low salt Low Cholesterol Vegetarian

Diabetic (please identify calorie count) _____

Other _____

Describe your appetite: Good Fair Poor

Have you had a recent weight change? Yes No

If yes, was the change a: Gain Loss

How many pounds _____

Do you have any difficulty or special needs with passing urine or stool? Yes No

Urinary Catheter Constipation On Dialysis

Colostomy Ileostomy Urinary Tract Infections

Other _____

17. Do you have any problems with (check all that apply): Taste Touch/Feel Smell

Do you have any problems with you vision? Yes No

Vision aids used: Glasses Contact Lenses

Do you have any problems with you hearing? Yes No

Hearing aids used: _____

Form completed by _____ Date _____

If other than the patient, please identify the relationship _____

Reviewed by _____ Title _____ Date _____