

Patient History Form

Last Name: _____ First Name: _____ Middle: _____

Reason for visit: _____

Constitutional

Fever
Chills
Headache
Other _____

Gastrointestinal

Abdominal Pain
Nausea/Vomiting
Heartburn
Other _____

Genitourinary

Urine Retention
Painful Urination
Frequency
Other _____

Eyes

Blurred Vision
Double Vision
Pain
Other _____

Cardiovascular

Chest Pain
Varicose Veins
High Blood Pressure
Other _____

Respiratory

Wheezing
Frequent Cough
Shortness of Breath
Other _____

Allergic/Immunologic

Drug
Food
Environmental
Other _____

Integumentary

Skin Rash
Boils
Persistent Itch
Other _____

Hematologic

Swollen Glands
Blood Clotting Problem
Other _____

Neurological

Tremors
Dizzy Spells
Numbness
Other _____

Musculoskeletal

Joint Pain
Neck Pain
Back Pain
Other _____

Psychologic

Anxiety
Depressed
Satisfied with life
Other _____

Endocrine

Excessive Thirst

Too hot/cold

Tired/sluggish

Other _____

Ear/Nose/Throat/Mouth

Ear Infection

Sore Throat

Sinus Problems

Other _____

Non RX drugs Yes No

Herbs Yes No

Vitamins Yes No

Do you smoke? _____ How much? _____ Do you drink alcohol? _____ How much? _____

Do you use recreational drugs? _____ What Kind? _____

Family Medical History (List all serious illnesses in your immediate family)

Personal Medical History

Personal Surgical History with dates

List All Prescription Medication You Take

Do you have allergies? Yes No Please List

Patient Name (please print) _____

Patient Signature _____

Date _____ DOB _____