

PRESENT ILLNESS

What is the primary problem for which you are seeking care today?

How long have you had this problem? _____

Did your symptoms develop gradually or suddenly? _____

Was there a specific injury? What type? _____

Were you injured at work or in a motor vehicle accident? _____

Is the problem improving or getting worse? _____

How severe is the problem (minor/moderate/severe)? _____

How frequent are your symptoms (constant/intermittent)? _____

What factors cause the symptoms to increase? _____

What factors cause the symptoms to decrease? _____

What parts of your body are affected? _____

What is the quality of your pain (dull/sharp/burning)? _____

Any associated symptoms (numbness/tingling/weakness)? _____

Height _____ **Weight** _____

PAST MEDICAL HISTORY (list all medical problems)

PAST SURGICAL HISTORY (list all prior operations)

MEDICATIONS (list all medications)

ALLERGIES _____

SOCIAL HISTORY

Do you smoke cigarettes? _____ packs/day? _____

Do you drink regularly? _____ drinks/day? _____

Occupation ? _____

Child Immunizations: yes _____ no _____

FAMILY HISTORY

Major medical problems in siblings?

Major medical problems in parents?

REVIEW OF SYSTEMS

Have you experienced any of the following symptoms or health problems?

<i>SYMPTOM / HEALTH PROBLEM</i>	<i>YES</i>	<i>NO</i>
Fever		
Weight loss		
Night sweats		
Swallowing problems		
Sleep apnea		
Chest pain		
Shortness of breath		
Gastric ulcers		
Incontinence		
Difficulty with urination		
Osteoarthritis		
Joint pain		
Skin rash		
Seizure disorder		
Depression		
Anxiety		
Serious personal problems		
Bleeding disorder		
Excessive bleeding after surgery		
Diabetes		
Recent change in vision		
Latex allergy		

Patient Signature: _____

Physician Signature: _____