

PATIENT HISTORY FORM

CHART#:

Today's Date 11/02/2009

Last Name: MOUSE

First Name: MICKEY

Date Of Birth: 10/09/2001

Chief Complaint or the main reason for your visit today? (Describe your complaint in detail)

History of Present Illness (Please answer the following questions completely or write N/A)

Location of the problem

Abdomen Back Leg

Other _____

Front

Back



Is anything else occurring at the same time?

YES NO If yes, please explain.

Nausea Rash Headaches

Other _____

AT ITS WORST.....On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

Does anything make the problem better?

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Does anything make the problem worse?

How long does the problems last? _____

Is the problem constant or variable?

Dull then Sharp Very sharp then leaves Always there Other _____

Does the problem interfere with your normal functions?

Yes ☐ No ☐ If yes, please explain

MD ONLY: (COMMENTS/NOTES)

ANSWERS

1-3

4 +

LEVEL

1 OR 2

3-5

Past Medical, Family & Social History

(List all serious illnesses in your immediate family. Please fill in every box with information or N/A)

DISEASE	PARENTS	BROTHERS	CHILDREN	DISEASE	PARENTS	BROTHERS	CHILDREN	Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much? _____
DIABETES				BLEEDING				Do you drink? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much? _____
CANCER				KIDNEY PROBLEM				Do you exercise regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much? _____
HEART DISEASE				OTHER				Married: _____ # of Children: _____
HIGH BLOOD PRESSURE				OTHER				

Past Illness and Dates

Illnesses

Date

_____	_____
_____	_____
_____	_____
_____	_____

Past Surgeries and Dates

Surgeries

Date

_____	_____
_____	_____
_____	_____
_____	_____

Comments:

MD ONLY: (COMMENTS/NOTES)

ANSWERS

1-3

4 +

LEVEL

1 OR 2

3-5



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