

# 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)

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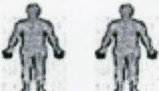
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## History of Present Illness (Please answer the following questions completely or write N/A)

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
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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?
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When did you first notice the problem? 2 days ago 2 weeks ago 1 month ago	Does anything make the problem worse?
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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 <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain
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MD ONLY: (COMMENTS/NOTES)	# ANSWERS 1-3 4 +	LEVEL 1 OR 2 3-5
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## 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? _____  Do you drink? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much? _____  Do you exercise regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much? _____  Married: _____ # of Children: _____
DIABETES				BLEEDING				
CANCER				KIDNEY PROBLEM				
HEART DISEASE				OTHER				
HIGH BLOOD PRESSURE				OTHER				

<b>Past Illness and Dates</b> <table border="1"> <thead> <tr> <th>Illnesses</th> <th>Date</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </tbody> </table>	Illnesses	Date	_____	_____	_____	_____	_____	_____	_____	_____	<b>Past Surgeries and Dates</b> <table border="1"> <thead> <tr> <th>Surgeries</th> <th>Date</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </tbody> </table>	Surgeries	Date	_____	_____	_____	_____	_____	_____	_____	_____	<b>Comments:</b>   
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