Patient History Form

Name:		**MR#:**	
DOB:		**Encounter Date:**	
Age:	year	**Sex:**	Male

Chief Complaint

☐ Abdominal pain	☐ Constipation	☐ COPD	☐ Allergic Rhinitis
☐ Anemia	☐ Asthma	☐ Back Pain	☐ Bloody stools
☐ BPH	☐ Cerumen impaction	☐ Chest Pain	☐ Conjunctivitis
☐ Cough	☐ Depression	☐ Diabetes	☐ Diarrhea
☐ Earache	☐ Erectile dysfunction	☐ Fever	☐ Fatigue
☐ Hypothyroidism	☐ Headache	☐ Hypertension	☐ Insomnia
☐ Obesity	☐ Palpitations	☐ Runny nose	☐ Sinusitis
☐ URI / Cold Symptoms	☐ UTI / Bladder Infection	☐ Vomiting / Nausea	☐ Vertigo / Dizziness
☐ Anxiety	☐ Hyperlipidemia	☐ Heartburn / GERD	☐ Rash / Itching
☐ Hot Flashes	☐ Eye Problems	☐ Irritable Bowel Syndrome	☐ Joint Pain
☐ Pharyngitis / Sore Throat	☐ Shortness of Breath	☐ Vaginal Irritation	☐ Skin Problem
☐ Swelling/Edema			

If other complaint, please describe:	

Allergies/Sensitivities

☐ **No Significant Allergies**

Allergy		**Reaction**	**Allergy**		**Reaction**
1.			2.		
3.			4.		
5.			6.		
7.			8.		
9.			10.		

Current Medications

☐ **No Known Current Medication**

Medication Name		**Medication Name**	
1.		2.	
3.		4.	

5.		6.	
7.		8.	
9.		10.	

Please enter additional Current Medication details if any:	

Surgical History

☐ **No Significant Past Surgical History**

Surgery	When	Doctor	Hospital
☐ Adenoidectomy			
☐ Appendectomy			
☐ CABG			
☐ Cesarean Section			
☐ Cholecystectomy			
☐ Cataract Surgery			
☐ Colposcopy			
☐ Gastric Bypass			
☐ Hysterectomy			
☐ Myringotomy / Tubes in ears			
☐ Sinus Surgery			
☐ Tonsillectomy			
☐ Vasectomy			
☐ Joint replacement			
☐ Breast Surgery			
☐ Hernia Repair			
☐ Back Surgery			
☐ Tubal Ligation			
☐ Thyroidectomy			
☐ Neck Surgery			
☐ Angioplasty			

Please enter additional Surgical History details if any:	

Past Medical History

☐ **No Significant Past Medical History**

Medical History	When	Comments
☐ Alcoholism		
☐ Anemia		
☐ Anxiety		

☐ Arthritis		
☐ Asthma		
☐ Cancer		
☐ Coronary Heart Disease		
☐ Diabetes		
☐ GERD		
☐ Gout		
☐ High Blood Pressure		
☐ Sinusitis		
☐ Stroke		
☐ Substance Abuse		
☐ Thyroid Disorder		
☐ ADD / ADHD		
☐ High Cholesterol Level		
☐ Back Injuries/Back Pain		
☐ BPH		
☐ Irritable Bowel Syndrome		
☐ COPD		
☐ Sleep Apnea		
☐ Depression		
☐ Insomnia		

Please enter additional Past Medical History details if any:	

Family History

☐ **No Known Family History**

Family History		**Relation**	**Comments**
1.			
2.			
3.			
4.			
5.			
6.			

Please enter additional Family History details if any:	

Social History

Employment:	
Marital Status:	
Children:	

Exercise:	
Pets:	
Sexual history:	
Pregnancy:	○ No ○ Yes
Alcohol:	
Smoking Status:	
Caffeine:	
Current use of recreational or street drugs:	

Please enter additional Social History details if any:	

Review Of Systems

Constitutional Symptoms	○ **Select** ○ **Deselect**		
Appearance	○ Normal ○ Abnormal	Disability	○ Denies ○ Reports
Fever	○ Denies ○ Reports	Chills	○ Denies ○ Reports
Malaise/Fatigue	○ Denies ○ Reports	Night sweats	○ Denies ○ Reports
Recent weight changes			
Comments			
Eyes	○ **Select** ○ **Deselect**		
Blurred vision	○ Denies ○ Reports	Double vision	○ Denies ○ Reports
Photophobia	○ Denies ○ Reports	Visual changes	○ Denies ○ Reports
Discharge	○ Denies ○ Reports	Glaucoma	○ Denies ○ Reports
Itching	○ Denies ○ Reports	Watery Eyes	○ Denies ○ Reports
Pain	○ Denies ○ Reports	Redness of eyes	○ Denies ○ Reports
Eyeglasses	○ Denies ○ Reports	Contact lens	○ Denies ○ Reports
Comments			
Ears/Nose/Mouth/Throat	○ **Select** ○ **Deselect**		
Hearing loss	○ Denies ○ Reports	Ear pain	○ Denies ○ Reports
Tinnitus / Ringing in Ears	○ Denies ○ Reports	Nasal congestion	○ Denies ○ Reports
Nasal discharge	○ Denies ○ Reports	Abnormal sneezing	○ Denies ○ Reports
Bleeding from nose	○ Denies ○ Reports	Postnasal drip	○ Denies ○ Reports
Oral ulcers	○ Denies ○ Reports	Oro-dental problems	○ Denies ○ Reports
Sore throat	○ Denies ○ Reports	Sensation of a lump in the throat	○ Denies ○ Reports
Swollen glands in neck	○ Denies ○ Reports	Ulcerations	○ Denies ○ Reports
Sensation of room spinning	○ Denies ○ Reports		
Comments			
Cardiovascular	○ **Select** ○ **Deselect**		
Chest pain	○ Denies ○ Reports	Murmur	○ Denies ○ Reports
Palpitation	○ Denies ○ Reports	Claudication	○ Denies ○ Reports
Dyspnea	○ Denies ○ Reports	Orthopnea	○ Denies ○ Reports

Edema	○ Denies ○ Reports	Previous EKG	
Comments			
Respiratory	○ **Select** ○ **Deselect**		
Cough	○ Denies ○ Reports	Shortness of breath	○ Denies ○ Reports
Chest tightness	○ Denies ○ Reports	Hemoptysis	○ Denies ○ Reports
Asthma	○ Denies ○ Reports	Wheezing	○ Denies ○ Reports
Comments			
Gastrointestinal	○ **Select** ○ **Deselect**		
Nausea/vomiting	○ Denies ○ Reports	Change in bowel habits	○ Denies ○ Reports
Diarrhea	○ Denies ○ Reports	Constipation	○ Denies ○ Reports
Abdominal pain	○ Denies ○ Reports	Difficulty with swallowing	○ Denies ○ Reports
Blood in stools	○ Denies ○ Reports	Hemorrhoids	○ Denies ○ Reports
Comments			
Genitourinary	○ **Select** ○ **Deselect**		
Blood in urine	○ Denies ○ Reports	Painful urination	○ Denies ○ Reports
Excessive nighttime urination	○ Denies ○ Reports	Urinary frequency	○ Denies ○ Reports
Hesitancy	○ Denies ○ Reports	Urinary urgency	○ Denies ○ Reports
Dribbling	○ Denies ○ Reports	Decreased urine stream	○ Denies ○ Reports
Abnormal discharge	○ Denies ○ Reports	Burning	○ Denies ○ Reports
Itching	○ Denies ○ Reports	Dyspareunia	○ Denies ○ Reports
History of urinary tract/bladder/kidney infection	○ Denies ○ Reports		
Comments			
Female GU	○ **Select** ○ **Deselect**		
LMP		Age at onset of menstruation	
Average cycle length		Shortest cycle length	
Longest cycle length		No. of pregnancies - live births	
No.of abortions		No. of miscarriages	
No. of stillbirths		Date of last PAP smear	
Painful menstruation	○ Denies ○ Reports	Heavy periods	○ Denies ○ Reports
Menstrual tension	○ Denies ○ Reports	PMS	○ Denies ○ Reports
Hot flashes/night sweats	○ Denies ○ Reports	Recent breast tenderness/lumps	○ Denies ○ Reports
Abnormal vaginal discharge	○ Denies ○ Reports	Prior D and C	○ Denies ○ Reports
C-section	○ Denies ○ Reports	Hysterectomy	○ Denies ○ Reports
Abnormal PAP smear	○ Denies ○ Reports	Pregnancy	○ Denies ○ Reports
Comments			
Male GU	○ **Select** ○ **Deselect**		
Lumps/pain in testicles	○ Denies ○ Reports	Difficulty with erection/ejaculation	○ Denies ○ Reports

Abnormal discharge from penis	○ Denies ○ Reports	Date of last prostate exam	
Comments			
Musculoskeletal	○ **Select** ○ **Deselect**		
Joint pain	○ Denies ○ Reports	Neck pain	○ Denies ○ Reports
Back pain	○ Denies ○ Reports	Upper extremity pain	○ Denies ○ Reports
Lower extremity pain	○ Denies ○ Reports	Shoulder pain	○ Denies ○ Reports
Numbness/tingling sensations	○ Denies ○ Reports		
Comments			
Integumentary	○ **Select** ○ **Deselect**		
Change in skin color	○ Denies ○ Reports	Change in hair/nails	○ Denies ○ Reports
Itching	○ Denies ○ Reports	Rashes	○ Denies ○ Reports
Varicose veins	○ Denies ○ Reports		
Comments			
Neurological	○ **Select** ○ **Deselect**		
Weakness	○ Denies ○ Reports	Convulsions/seizures	○ Denies ○ Reports
Migraine headaches	○ Denies ○ Reports	Numbness	○ Denies ○ Reports
Decrease in cognitive skills	○ Denies ○ Reports	Loss of balance	○ Denies ○ Reports
Head injury	○ Denies ○ Reports	Paralysis	○ Denies ○ Reports
Tremors	○ Denies ○ Reports	Dizziness	○ Denies ○ Reports
Comments			
Psychiatric	○ **Select** ○ **Deselect**		
Difficulty concentrating	○ Denies ○ Reports	Insomnia	○ Denies ○ Reports
Changes in socializing	○ Denies ○ Reports	Irritability/mood changes	○ Denies ○ Reports
Suicidal thoughts/attempts	○ Denies ○ Reports	Anxiety	○ Denies ○ Reports
Depression	○ Denies ○ Reports	Forgetfulness	○ Denies ○ Reports
Nervousness	○ Denies ○ Reports	Adequate/sound sleep	○ Denies ○ Reports
Previous use of psychotropic medication	○ Denies ○ Reports		
Comments			
Endocrine	○ **Select** ○ **Deselect**		
Heat/cold intolerance	○ Denies ○ Reports	Excessive urination	○ Denies ○ Reports
Changes in hat/glove size	○ Denies ○ Reports	Nocturia	○ Denies ○ Reports
Glandular/hormonal problem	○ Denies ○ Reports	Excessively dry skin	○ Denies ○ Reports
Comments			
Hematologic/Lymphatic	○ **Select** ○ **Deselect**		
Anemia	○ Denies ○ Reports	Easy bruising/bleeding	○ Denies ○ Reports
Night sweats	○ Denies ○ Reports	Tenderness in the nodes of neck/groin area	○ Denies ○ Reports
Slow healing wounds	○ Denies ○ Reports	Past transfusions	○ Denies ○ Reports
Phlebitis	○ Denies ○ Reports		
Comments			

Please enter additional Review Of Systems details if any:	

Thank you for completing the Form. Please click on **SAVE & SUBMIT**