

PATIENT MEDICAL HISTORY REVIEW

Patient Name: _____ Date of Birth: _____

Current or Past Occupation: _____

CHIEF COMPLAINT: What is the main reason for your visit today? (Describe problem in detail):

HISTORY OF PRESENT ILLNESS

QUESTION & EXAMPLE	YOUR ANSWER
Location of the Problem: Abdomen, Back, Leg, etc.	
On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?	Mild Severe 1 2 3 4 5 6 7 8 9 10
When did you first notice the problem? 2 days ago @ 4am, 2 weeks ago, 1 month ago	
Does anything help or make the problem worse? Moving around, Standing up, Lying on my side	
How long does the problem last? 30 minutes, 1 hour, it is always there	
Is anything else occurring at the same time? Nausea, rash, headaches	
Is the problem constant or variable? Dull than sharp, Very sharp then leaves, Always There	
Does the problem interfere with your normal Functions? If yes, please explain.	

PAST MEDICAL AND SOCIAL HISTORY
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If you are taking any medications, please list below:

Name of Medication	Dosage	Prescribed By

If you have ever had surgery before, please list below:

Date	Type of Surgery	Hospital or Surgeon

List all serious illnesses in your family. Diabetes, tuberculosis, cancer, heart disease, Etc.	
What is your age? What is your weight? What is your height?	Age: Weight: Height:
Do you smoke? If yes, how much per day?	
Do you drink? If yes, how much per day?	
Are you on a special diet? If yes, please explain.	
Do you have any allergies? If yes, please explain.	

REVIEW OF SYSTEMS		
Do you now or have you had any problems related to the following systems? If yes, explain:		
Constitutions Symptoms: Fever, Chills, headache	NO	YES – Explain:
Eyes: Blurred Vision, Double Vision, Pain	NO	YES – Explain:
Allergic/Immunologic: Hay Fever, Drug Allergies, Other	NO	YES – Explain:
Neurological: Tremors, Dizzy Spells, Numbness/Tingling	NO	YES – Explain:
Endocrine: Excessive Thirst, Too Hot/Cold, Tired/sluggish	NO	YES – Explain:
Gastrointestinal: Abdominal Pain, Nausea/Vomiting, Indigestion/Heartburn	NO	YES – Explain:
Cardiovascular: Chest Pain, Varicose Veins, High Blood Pressure	NO	YES – Explain:
Integumentary: Skin Rash, Boils, Persistent Itch	NO	YES – Explain:
Musculoskeletal: Joint Pain, Neck Pain, Back Pain	NO	YES – Explain:
Ear/Nose/Throat/Mouth: Ear Infection, Sore Throat, Sinus Problems	NO	YES – Explain:
Genitourinary: Urine Retention, Painful Urination, Urinary Frequency, Incontinence	NO	YES – Explain:
Respiratory: Wheezing, Frequent Cough, Shortness of Breath	NO	YES – Explain:
Psychological: Are you dissatisfied with your life? Do you feel Severely depressed? Have you considered suicide?	NO	YES – Explain:
Do you ever take aspirin or blood thinning medications?	NO	YES – Explain:
Are you allergic to any medications	NO	YES – Explain:

Have you ever had a stroke?	NO	YES – Explain:
Have you ever had diabetes?	NO	YES – Explain:
Have you ever had hepatitis or liver disease?	NO	YES – Explain:
Have you ever been told you have cancer?	NO	YES – Explain:
Is there any family history of cancer?	NO	YES – Explain:
Have you ever had a problem with alcohol or drugs?	NO	YES – Explain:
Females: Is there any chance you could be pregnant? Date of last menstrual period:	NO	YES – Explain:
Have you ever seen blood in your urine?	NO	YES – Explain:
Do you sense any burning or pain when you urinate?	NO	YES – Explain:
Do you have trouble starting a urine stream?	NO	YES – Explain:
Does your bladder feel empty after your finish urinating?	NO	YES – Explain:
Do you ever leak urine or wet yourself?	NO	YES – Explain:
Have you ever had problems with your kidneys?	NO	YES – Explain:
Have you ever had a bladder or kidney stone?	NO	YES – Explain:
Have you ever had problems with your bladder?	NO	YES – Explain:
Men: Have you ever had prostate problems?	NO	YES – Explain:
Men: Have you ever experienced impotence?	NO	YES – Explain:
How many times do you awake each night to urinate?		0 1 2 3 4 5 more than 5 times
How often do you urinate during the daytime?		Every _____ hours

Patient Signature: _____ Date _____

Physician Signature: _____ Date _____