



Patient History Form

Patient Information

Patient Name

What is your main reason for seeing the doctor today?

Patient History Questionnaire

List the illnesses for which you have been treated: (for example, diabetes or high blood pressure, etc.)

List all surgeries that you have had: (Include Date and Type of Surgery)

Social History

Do you smoke? Yes No

Do you drink alcohol? Yes No

Occupation:

Family History

Does your blood relatives have:

Diabetes? Yes No

Cancer? Yes No

High Blood Pressure? Yes No

Kidney Disease? Yes No

Other?

List all medications you are currently taking including vitamins, supplements, aspirin, etc.

List all allergies to medicine, food, or x-ray dye:

Patient History Review

General:

- Unexplained Weight Loss
- Excessive Fatigue

Eyes:

- Blurred Vision
- Double Vision
- Pain

Ears/Nose/Mouth:

- Frequent Ear Infections
- Frequent Nose Bleeds
- Hay Fever or Sinus Trouble

Cardiovascular:

- Pain or Pressure in Chest
- Dizziness
- Palpitations
- Swelling of Ankles

Respiratory:

- Shortness of Breath
- Chronic Cough
- Coughing up Blood
- Asthma

Gastrointestinal:

- Abdominal Pain
- Persistent Constipation
- Frequent Indigestion
- Bleeding

Genitourinary:

- Blood in Urine
- Kidney Stones
- Irregular Vaginal Bleeding

Musculoskeletal:

- Arthritis
- Other

Skin:

- Persistent Rash
- Other

Neurological:

- Frequent Headaches
- Seizures or Fainting Spells
- Weakness or Paralysis

Psychiatric:

- Depression or Anxiety

Endocrine:

- Excess Thirst

Hematologic/Lymphatic:

- Easy Bruising or Bleeding
- Swollen Glands -

Other:

List primary care doctor and all specialists that you are seeing: (Include Physician Name, Phone, and Location)

SUBMIT PATIENT HISTORY

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