

Today's Date: _____

THANK YOU FOR COMPLETING THIS COMPREHENSIVE HISTORY FORM

Name: _____ Date of birth _____ / _____ / _____

Describe your main problem: _____

Where is your problem located? _____

How severe is your problem? _____

How long have you had this problem? _____

When does this problem occur? _____

What were you doing when it started? _____

What other things happen with this problem? _____

List previous hospitalizations/surgeries/serious injuries _____

When/Age _____

List other doctors who you see: _____

List **allergies** you have:

Medications/supplements/vitamins
you've been taking:

Have you and/or your family ever had the following?

	You	Mother	Father	Brother(s)	Sister(s)	Comments:
Diabetes	☐	☐	☐	☐	☐	_____
Heart Trouble.....	☐	☐	☐	☐	☐	_____
Hypertension	☐	☐	☐	☐	☐	_____
Lung problems	☐	☐	☐	☐	☐	_____
Cancer.....	☐	☐	☐	☐	☐	_____
Stroke.....	☐	☐	☐	☐	☐	_____
Arthritis/Gout	☐	☐	☐	☐	☐	_____
Convulsions	☐	☐	☐	☐	☐	_____
Bleeding Tendency ...	☐	☐	☐	☐	☐	_____
Acute Infections.....	☐	☐	☐	☐	☐	_____
Hereditary Defects	☐	☐	☐	☐	☐	_____
Mental Illness.....	☐	☐	☐	☐	☐	_____
Deceased.....	☐	☐	☐	☐	☐	_____

Patient Social History: Who lives with you? ☐ Spouse ☐ I live alone ☐ other _____

What is your current occupation? _____ or ☐ Retired _____

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other _____

Do you drink alcohol? ☐ Never ☐ Rarely ☐ Moderately ☐ Daily _____

Tobacco Use? ☐ Never or ☐ Yes, when? _____ How much/often? _____

Use of Drugs? ☐ Never ☐ Type/Frequency _____

Do you drink caffeinated beverages? ☐ Never ☐ Sometimes ☐ Quite often What kind? ☐ Coffee ☐ Soft Drinks

Have you had any problems of falling in the past year? ☐ No ☐ Yes/Describe _____

Do you feel safe at home? ☐ Yes ☐ No/Describe _____



Are you **currently** experiencing any of the following? Please answer ALL questions!

CONSTITUTIONAL

Recent weight change No Yes
 Fever No Yes
 Chills No Yes
 Fatigue No Yes

EYES

Eye disease or injury..... No Yes
 Wear glasses/contact lenses No Yes
 Blurred or double visions No Yes

ENT

Hearing loss..... No Yes
 Ringing in the ears..... No Yes
 Earaches or drainage..... No Yes
 Sinus problems No Yes
 Nose bleeds..... No Yes
 Mouth sores No Yes
 Bleeding gums..... No Yes
 Bad breath or bad taste No Yes
 Sore throat or voice change..... No Yes

CARDIOVASCULAR

Heart trouble No Yes
 Chest pains..... No Yes
 Sudden heart beat change..... No Yes
 Swelling of feet, ankles or hands No Yes

RESPIRATORY

Frequent coughing No Yes
 Spitting up blood No Yes
 Shortness of breath..... No Yes
 Asthma or wheezing No Yes

GASTROINTESTINAL

Loss of appetite No Yes
 Change in bowel movements No Yes
 Nausea No Yes
 Vomiting..... No Yes
 Diarrhea No Yes
 Blood in stool No Yes
 Stomach No Yes

GENITOURINARY

Frequent urination No Yes
 Burning or painful urination..... No Yes
 Blood in urine..... No Yes
 Change or force of strain when urinating..... No Yes
 Incontinence or dribbling No Yes
 Kidney stones No Yes
 Sexual difficulty No Yes

Male: Testicle pain No Yes

Female: Last menstrual period _____
 (date)

Do you have

pain with periods? No Yes
 irregular periods? No Yes
 vaginal discharge? No Yes

pregnancies _____ # miscarriages _____

date of last pap smear _____

last pap smear was ☐ normal ☐ abnormal

MUSCULOSKELETAL

Joint pain No Yes
 Joint stiffness or swelling No Yes
 Weakness of muscles or joints No Yes
 Muscle pain or cramps..... No Yes
 Back pain..... No Yes
 Difficulty in walking No Yes

SKIN

Rash or itching..... No Yes
 Change in skin color No Yes
 Change in hair or nails..... No Yes
 Varicose veins No Yes
 Breast pain..... No Yes
 Breast lump No Yes
 Breast discharge No Yes

NEUROLOGICAL

Headaches No Yes
 Dizziness..... No Yes
 Convulsions or seizures No Yes
 Numbness or tingling No Yes
 Tremors No Yes
 Paralysis..... No Yes
 Stroke No Yes
 Head injury No Yes

PSYCHIATRIC

Memory loss or confusion..... No Yes
 Nervousness No Yes
 Depression..... No Yes
 Sleep problems..... No Yes

ENDOCRINE

Diabetes No Yes
 Hormone problems..... No Yes
 Thyroid disease..... No Yes
 Excessive thirst or urination..... No Yes
 Heat or cold intolerance No Yes
 Dry skin No Yes
 Change in hat, glove or shoe size No Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts No Yes
 Easily bruise or bleed No Yes
 Anemia No Yes
 Phlebitis..... No Yes
 Past transfusion..... No Yes
 Enlarged glands..... No Yes

ALLERGIC/IMMUNOLOGIC

Hay fever or seasonal allergies..... No Yes

History of skin reaction or other adverse reactions to:

Penicillin or other antibiotics..... No Yes
 Morphine, Demerol or other narcotics..... No Yes
 Novocaine or other anesthetics No Yes
 Aspirin or other pain remedies No Yes
 Tetanus antitoxin or other serums..... No Yes
 Iodine, metholate or other antiseptics..... No Yes
 Latex No Yes

Patient Signature: _____

Physician Signature: _____