

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date ___/___/___ Date of Last Physical Exam ___/___/___

Last Name _____ First Name _____ Middle _____

Social Security # _____ Date of Birth ___/___/___

Chief Complaint

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

History of Present Illness

Please answer the following questions

<p>Location of problem Abdomen Back Leg Other _____ _____</p> <p>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</p> <p>When did you first notice the problem? 2 days ago 2 weeks ago 1 month ago Other _____</p> <p>Does anything help or make the problem worse? Moving around Standing Up Lying on my side Other _____</p>	<p>How long does the problem last? 30 minutes 1 hour It is always there Other _____</p> <p>Is anything else occurring at the same time? Nausea Rash Headaches Other _____</p> <p>Is the problem constant or variable? Dull then Sharp Very sharp then leaves Always there Other _____</p> <p>Does the Problem interfere with your normal functions? Yes No If yes, please explain _____ _____</p>
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Circle Your Score

Write Score Here

	0	1	2	3	4	5	
1. INCOMPLETE EMPTYING: In a 24-hour period, how often have you had a sensation of not emptying your bladder?	0 Times	1 Time	2 Times	3 Times	4 Times	5 Times	
2. FREQUENCY: In a 24-hour period, how often have you had to urinate again less than 2 hours after you finished urinating?	0 Times	1 Time	2 Times	3 Times	4 Times	5 Times	
3. INTERMITTENCY: In a 24-hour period, how often have you found that you stopped and started again several times when you urinated?	0 Times	1 Time	2 Times	3 Times	4 Times	5 Times	
4. URGENCY: In a 24-hour period, how often do you find it difficult to postpone urination?	0 Times	1 Time	2 Times	3 Times	4 Times	5 Times	
5. WEAK STREAM: In a 24-hour period, how often do you have a weak urinary stream?	0 Times	1 Time	2 Times	3 Times	4 Times	5 Times	
6. STRAINING: In a 24-hour period, how often have you had to push or strain to begin urination?	0 Times	1 Time	2 Times	3 Times	4 Times	5 Times	
7. NOCTURIA: How many times do you get up to urinate from the time you go to bed at night until the time you get up in the morning?	0 Times	1 Time	2 Times	3 Times	4 Times	5 Times	
TOTAL SCORE _____							

(OVER)

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.
Please explain any YES answers in the space provided.

Constitutional Symptoms

Fever Y N
Chills Y N
Headache Y N
Other _____

Eyes

Blurred Vision Y N
Double Vision Y N
Pain Y N
Other _____

Allergic/Immunologic

Hay Fever Y N
Drug Allergies Y N
Other _____

Neurological

Tremors Y N
Dizzy Spells Y N
Numbness/Tingling Y N
Other _____

Endocrine

Excessive Thirst Y N
Too Hot/Cold Y N
Tired/Sluggish Y N
Other _____

Gastrointestinal

Abdominal Pain Y N
Nausea/Vomiting Y N
Indigestion/Heartburn Y N
Other _____

Cardiovascular

Chest Pain Y N
Varicose Veins Y N
High Blood Pressure Y N
Other _____

Integumentary

Skin rash Y N
Boils Y N
Persistent itch Y N
Other _____

Musculoskeletal

Joint Pain Y N
Neck Pain Y N
Back Pain Y N
Other _____

Ear/Nose/Throat/Mouth

Ear Infection Y N
Sore Throat Y N
Sinus Problems Y N
Other _____

Genitourinary

Urine Retention Y N
Painful Urination Y N
Urinary Frequency Y N
Other _____

Respiratory

Wheezing Y N
Frequent Cough Y N
Shortness of Breath Y N
Other _____

Hematological/Lymphatic

Swollen Glands Y N
Blood Clotting Problem Y N
Other _____

Psychological

Are you generally satisfied with your life? Y N
Do you feel severely depressed? Y N
Have you considered suicide? Y N
Other _____

Past Medical & Social History

List all serious illnesses in your immediate family. (Ex. Diabetes, Tuberculosis, Breast Cancer, Heart Disease, High Blood Pressure, etc.)

List any personal past illnesses and/or surgeries and when they occurred. Illness or Surgery and Date.

Are you taking any medications? Y N (If yes, list all.)

Are you on a special diet? Y N (If yes, please explain.)

Do you have any allergies? Y N (If yes, please explain.)

Do you smoke? Y N
If yes, how much? _____

Do you drink? Y N
If yes, how much? _____

Physician: _____

Date: ____/____/____