

Comprehensive Patient History

Acct# _____

Patient Name: _____

Date of Birth: _____

Date: _____

What is the reason for visit? _____

Describe the following:

Location: _____

How long have you had this problem? _____

How severe is the problem? Mild Moderate Severe

How often are you having the problem? _____

What caused the problem? _____

Do you know of anything else that may have contributed to this problem? _____

Does anything else occur with this problem? _____

Additional comments: _____

List previous hospitalizations/surgeries/ serious injuries

When?

Prior testing for this problem:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Patient Social History

Marital Status: Single Married Separated Divorced Widowed

Use of alcohol: Never Rarely Moderate Daily _____

Use of tobacco: Never Previously but quit Current packs per day _____

Use of Drugs: Never Type/Frequency _____

Excessive exposure at home or work to: Fumes Dust Solvent: Noise

Occupation: _____ Last Completed Level of Education: _____

Hobbies: _____

Have you ever had the following?			Diabetes.....	yes	no	High Blood Pressure.....	yes	no
Cancer.....	yes	no	Stroke.....	yes	no	Heart trouble.....	yes	no
Arthritis/Gout.....	yes	no	Convulsions.....	yes	no	Bleeding Tendency.....	yes	no
Infections.....	yes	no	Lung Disease.....	yes	no	Hereditary Defects.....	yes	no
Problems with anesthesia	yes	no						

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____