HISTORY

MRN#_____

Patient Name:_____ Age:_____ Date:_____

Reason for visit:_____

When did your problem start?_____

Referring Physician:_____

Past Medical History (Check all that apply) ____No Past Medical History

	Abnormal weight loss		Cancer _____		Hypertension
	Abnormal weight gain		Congestive Heart Failure		Obesity
	Alcoholism		Crohn's Disease		Peptic Ulcer
	Alzheimer's Disease		Diabetes Type I Type II		Pneumonia
	Angina		Diverticulitis		Seizures
	Anxiety Disorder		Esophageal Reflux		Sickle Cell
	Arthritis		Free Bleeder		Sleep Apnea
	Asthma		Heart Attack		Stroke
	Auto Immune Disease		Hepatitis (A, B, or C)		Ulcerative Colitis
	Bronchitis		HIV/AIDS		Vascular Disease

OTHER:_____

Family History (Check all that apply) ___No Past Family History

	Breast Cancer		Ovarian Cancer		Colon Cancer		Heart Attack		Sickle Cell

OTHER:_____

Surgical History (Please check all that apply) ____No Past Surgical History

	Adenoids/Tonsils/Both		Heart
	Appendix		Hemorrhoids
	Back Surgery		Hernia (Specify – hiatal - inguinal - incisional – ventral)
	Brain		Hysterectomy
	Breast		Lung
	Colon		Reflux
	C-Section		Thyroid
	Gallbladder		Vascular

OTHER:_____

Social History: (Please circle)

Smoke: Yes Not Anymore Never

Drink Alcohol: Yes Not Anymore Never

Recreational Drugs: Past Current

FEMALES ONLY

Reproductive History:

Number of Pregnancies ____

Number of Children____

Did you breastfeed? Yes No

Review of Symptoms

	Constitutional		Tenderness		Nausea		Urgency		**Endocrine**
	Fatigue		Swelling		Vomiting		Frequency		Loss of hair
	Fever		Nipple discharge		Diarrhea		Hematuria		constipation
	Chills		Abnormal changes in size		Constipation		Incontinence		Weight gain/loss
	Malaise		**Cardiovascular**		Loss of appetite		**Integument**		**Psychiatric**
	Body aches		Chest pain		Dysphagia		Rash		Anxiety
	Night sweats		Irregular heartbeat		Heartburn		Pigmentation chances		Depression
	Weight gain/loss		Rapid heart rate		Hematemesis		New skin lesions		Hallucinations
	Loss of appetite		Dyspnea on exertion		Excessive belching		Changes to existing skin		Delusions
	Eyes		**Respiratory**		Abdominal pain		Lesions or moles		Confusion
	Blurred vision		Shortness of breath		Jaundice		**Neurologic/musculoskeletal**		Difficulty sleeping
	HENT		Wheezing		Blood in stools		Joint pain or selling		Compulsive/impulsive behavior
	Headaches		Cough		Hemorrhoids		Muscle pain/cramps/weakness		Suicidal/homicidal ideation
	Vertigo		Hoarseness		Narrow stools		Pain - back neck shoulder		Marital/family problems
	Recent head injury		Abnormal sputum production		Excessive flatulence		Speech difficulties		**Heme-Lymph**
	Breasts		Hemoptysis (coughing blood)		Bloating		Seizures		Easy bleeding/bruising
	Lumps		**Bowels**		**Bladder**		Tingling or numbness		Lymph node enlargement or tenderness