

Last name _____ First _____ DOB _____ Date ____/____/____

Doctor (s) who referred you: _____

Chief complaint: _____
(reason for your visit)

History of present illness or injury **Is this illness/injury employment related?** Yes No
Please answer all questions. If one does not apply to you, please write N/A (not applicable).

Location: _____ Duration: _____
(Where on the body symptom occurs) (How long have you had symptom/pain? How long does it last?)

Severity: _____ Quality: _____
(Severe, worse slightly, Symptom/pain scale 1-10) (Character of symptoms/pain...burning, gnawing, stabbing, etc.)

Timing: _____ Context: _____
(When symptoms occur...after meals or exercise, etc.) (Situation associated with symptoms)

Modifying: _____ Associated Signs / Symptoms: _____
(Things to make symptoms better or worse) (Other things that happen when symptoms occur)

For office use only-- 1. Chief complaint/Hx of present illness Brief 1-3 Elements above Extended 4 or more Elements above

Past Medical History (Please an **X** in the box for current symptoms and use the circle **O** for past symptoms)

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Crohn's disease/ulcerative colitis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Colon/rectal cancer |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Heart valve damage | <input type="checkbox"/> Diverticulosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Abnormal heart rhythm | <input type="checkbox"/> Rectal bleeding |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Aortic aneurysm | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Carotid artery stenosis | <input type="checkbox"/> Peptic ulcer |
| <input type="checkbox"/> Lung cancer | <input type="checkbox"/> Peripheral artery disease | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Deep venous thrombosis | <input type="checkbox"/> Reflux disease |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Stroke | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Hepatitis type A/B/C/D |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Fecal incontinence |
| <input type="checkbox"/> Melanoma | <input type="checkbox"/> Prostate problems (BPH) | <input type="checkbox"/> Prostate cancer |
| <input type="checkbox"/> Breast mass | <input type="checkbox"/> Breast discharge | <input type="checkbox"/> Breast cancer |
| <input type="checkbox"/> Ovarian cyst | <input type="checkbox"/> Ovarian cancer | <input type="checkbox"/> Uterine cancer |
| <input type="checkbox"/> Sexual dysfunction | <input type="checkbox"/> Impotence | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Thyroid disorder hypo/hyper | <input type="checkbox"/> Hypercalcemia |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Diabetes type I/II | <input type="checkbox"/> Lupus | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Contact lenses | <input type="checkbox"/> Hearing aid |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Contact allergy _____ | <input type="checkbox"/> Environmental allergy |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Psychiatric problems _____ | <input type="checkbox"/> Epilepsy |

Other _____

Last _____ First _____ Date ____/____/____

Review of systems: Please circle Yes or No as appropriate: Answer all questions.

Constitutional

Good General Health Yes No
 Recent weight change Yes No
 Night sweats Yes No
 Fatigue, Malaise Yes No

Cardiovascular

Chest pain Yes No
 Palpitations Yes No
 Heart trouble Yes No
 Swelling hands/feet Yes No
 Leg cramps rest/walking Yes No

Musculoskeletal

Muscle pain or cramps Yes No
 Stiffness/swelling joints Yes No
 Joint pain Yes No
 Trouble walking Yes No
 Cane/walker Yes No

Endocrine

Excessive thirst/urination Yes No
 Thyroid disease Yes No
 Hormone problems Yes No
 Cold/heat intolerance Yes No
 Rapid heart beats Yes No

Hematologic/Lymphatic

Bruise easily Yes No
 Slow to heal Yes No
 Enlarged glands Yes No
 Leg clots Yes No
 Anemia Yes No

Allergic/Immunologic

Food allergies Yes No
 Aspirin allergy Yes No
 Antibiotic allergies Yes No

Respiratory

Shortness of breath Yes No
 Cough/phlegm Yes No
 Wheezing/Asthma Yes No
 Coughing up blood Yes No
 Oxygen use day/night Yes No

Neurological

Frequent headaches Yes No
 Paralysis or tremors Yes No
 Convulsions/seizures Yes No
 Numbness/tingling Yes No
 Weakness Yes No
 Balance problems Yes No

Genitourinary-Male only

Blood in urine Yes No
 Kidney stones Yes No
 Sexual problems Yes No
 Testicle pain Yes No
 Night urination Yes No
 Problem w/urination Yes No
 Lost bladder control Yes No

Genitourinary-Female only

Blood in urine Yes No
 Kidney stone Yes No
 Sexual problems Yes No
 Menstrual problems Yes No
 Lost bladder control Yes No

Breast

Lump Yes No
 Asymmetry Yes No
 Skin retraction Yes No
 Ulceration Yes No
 Flattening of nipple Yes No
 Discharge clear/bloody Yes No

Ears/Nose/Mouth/Throat

Hearing loss/or ringing Yes No
 Sinus problems Yes No
 Nose bleeds Yes No
 Sore throat/voice change Yes No
 Post nasal drip Yes No

Eyes

Wear glasses/contacts Yes No
 Blurred/double vision Yes No
 Eye disease or injury Yes No
 Glaucoma Yes No
 Yellow sclera Yes No

Gastrointestinal

Nausea/vomiting Yes No
 Abdominal pain Yes No
 Rectal bleeding Yes No
 Bowel problems Yes No
 Heartburn/dyspepsia Yes No
 Indigestion Yes No
 Appetite changes Yes No
 Difficulty swallowing Yes No
 Belching Yes No
 Feeding tube Yes No

Integumentary (skin)

Change in hair or nails Yes No
 Rashes or itching Yes No
 Pigmentation change Yes No
 Non-healing ulcer yes No

Psychiatric

Insomnia Yes No
 Confusion/memory loss Yes No
 Depression/anxiety Yes No
 Speech problems Yes No
 Hearing voices Yes No

Last _____ **First** _____ **Date** ____/____/____

Past Surgical History (*write the year at which the operation was done*)

- | | | |
|---|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Groin hernia | <input type="checkbox"/> Incisional/Ventral hernia |
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Small bowel obstruction |
| <input type="checkbox"/> Angioplasty/Stents | <input type="checkbox"/> Coronary artery by-pass | <input type="checkbox"/> Colon resection_____ |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Carotid artery surgery | <input type="checkbox"/> Hemorrhoidectomy |
| <input type="checkbox"/> Aortic aneurysm repair | <input type="checkbox"/> Leg artery by-pass | <input type="checkbox"/> Prostate TURP |
| <input type="checkbox"/> C-section | <input type="checkbox"/> Heart valve replacement | <input type="checkbox"/> Prostatectomy |
| <input type="checkbox"/> Breast biopsy | <input type="checkbox"/> D&C | <input type="checkbox"/> Penile implant |
| <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Hysterectomy Ovary L/R | <input type="checkbox"/> Bladder cancer treatment |
| <input type="checkbox"/> Breast implant | <input type="checkbox"/> Cervical cancer treatment | <input type="checkbox"/> Lithotripsy |
| <input type="checkbox"/> Breast reduction | <input type="checkbox"/> Abdominoplasty | <input type="checkbox"/> Plastic surgery type_____ |
| <input type="checkbox"/> Fractured bone _____ | <input type="checkbox"/> Arthroscopy _____ | <input type="checkbox"/> Laminectomy-Back operation |
| <input type="checkbox"/> Hip replacement L/R | <input type="checkbox"/> Knee replacement L/R | <input type="checkbox"/> Other prosthesis _____ |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Upper Endoscopy | <input type="checkbox"/> Bronchoscopy |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Radiotherapy | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Dialysis shunt | <input type="checkbox"/> Venous Access Device (port) | <input type="checkbox"/> Ventriculo-Peritoneal Shunt |

Other _____

Hospitalization

Year	Hospital	Illness, Operation, or Injury
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

	Living/age	Deceased/age	Diabetes	Hypertension	Stroke	Heart problems	Cancer type	Other
Mother	_____	_____	_____	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____	_____	_____	_____
Sister/Brother	_____	_____	_____	_____	_____	_____	_____	_____
Sister/Brother	_____	_____	_____	_____	_____	_____	_____	_____
Daughter/Son	_____	_____	_____	_____	_____	_____	_____	_____
Daughter/Son	_____	_____	_____	_____	_____	_____	_____	_____
Other_____	_____	_____	_____	_____	_____	_____	_____	_____

Have you had any of the following recently?

Well-being

Test	Date	Physician	Location	Test	Date	Physician	Location
Physical examination	_____	_____	_____	EKG	_____	_____	_____
Chest X-ray	_____	_____	_____	Stress test	_____	_____	_____
Blood work	_____	_____	_____	Colonoscopy	_____	_____	_____
Tetanus immunization	_____	_____	_____	Stool for blood	_____	_____	_____

Last _____ First _____ Date ____/____/____

Social History

Marital status Single Married Separated Divorced Widowed
Tobacco Never Quit/When _____ Current smoker/packs per day _____
Alcohol Never Rarely Moderate Daily/How Much? _____
Drug Use Never Type & Frequency _____
Occupation _____

Gynecological History

First menstruation age _____ Last day of current menses _____ Age of menopause _____
 Number of pregnancies _____ Full-term _____ Miscarriages _____ Abortion _____ C-section _____
 Name of your Gynecologist _____

Estrogen therapy Yes No Started _____ Finished _____
 Birth control pills Yes No IUD - Date _____
 Last mammogram _____ Breast exam _____ PAP-smear _____
 Previous breast biopsy Yes No Number of biopsies _____ Right Left
 Atypical Hyperplasia Yes No _____
 Number of Family Members with Breast Cancer
 Mother Sister(s) _____ Daughter(s) _____ Grandmother(s) _____ Aunt(s) _____

For office use only -- Gail Model Risk Assessment _____% 5 years _____% Lifetime

For office use only-- 3. Past, Family & Social History One/Two History Areas Three History

PLEASE SIGN AND DATE

Patient Statement To the best of my knowledge, the above information is accurate and complete.
 Signed: _____ Date ____/____/____

Physician Statement I have reviewed the questionnaire with the patient.
 Comments: _____

 Signed: _____ Date ____/____/____

For office use only--to score level of History, check appropriate boxes for each of the three history components. Use the lowest level checked.

Type of History	Expanded Problem Focused	Detailed	Comprehensive
1. Chief complaint/Hx of present illness	<input type="checkbox"/> Brief 1-3 elements		<input type="checkbox"/> Extended 4+
2. Past, Family & Social History		<input type="checkbox"/> 1-2 History areas	<input type="checkbox"/> 3 History areas
3. Review of Systems	<input type="checkbox"/> Problem Pertinent (1 system)	<input type="checkbox"/> Extended 2-9 systems	<input type="checkbox"/> Complete 10+ systems