

PATIENT HISTORY FORM

TODAY'S DATE ____/____/____ DATE OF LAST EXAM ____/____/____

NAME: LAST _____ FIRST _____ MIDDLE _____

SOCIAL SECURITY #: _____ DATE OF BIRTH ____/____/____

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

HAS ANYTHING CHANGED SINCE YOUR LAST VISIT? YES NO

History of Present Illness

Location of the problem	When did you first notice the problem?
Abdomen Back Leg	2 days ago 2 weeks ago 1 month ago
Other: _____	Other: _____
Picture:	How Long Does the problem last
	30 minutes 1 hour It is always there
	Other: _____
	Is anything else occurring at the same time?
	_____ Yes _____ No
	If yes please explain:
	Nausea Rash Headaches
	Other: _____
	Is the problem constant or variable?
On a scale of 1-10, with 10 being the most severe, Circle the number that best describes the problem	Dull then Sharp Very sharp then leaves Always there
1 2 3 4 5 6 7 8 9 10	Other _____

