WhidbeyHealth

Comprehensive Patient History Form

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Patient Name: ____________________; Date of Birth: ________; Age: ___________ Date: _________________

Race: _______________________________ Referring MD:_______________________________________

1. Describe your main reason for your visiting: ___

Where is your problem located? ____

How long have you had this problem? ____

2. Have you ever had the following?

Diabetes……………….	☐	Hypertension…………	☐	Cancer…	☐
Stroke………………….	☐	Heart trouble……	☐	Arthritis/gout	☐
Convulsions……………	☐	Bleeding tendency…	☐	Acute infections…	☐
Venereal disease……….	☐	Hereditary disease	☐	Kidney trouble	☐
Lung troubles	☐	Thyroid disease ………..	☐		

3. List previous hospitalizations/Surgeries/Serious Injuries When?

____ ____________________

____ ____________________

____ ____________________

____ ____________________

____ ____________________

List all allergies you have ever had

1)______________________________

2)______________________________

3)______________________________

4)______________________________

List current medications you are taking on separate sheet provided.

4. 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 _____

Occupation: present____________; Past______________________

5. Family Medical History

	Age	Diseases	If Deceased, Age and Cause
Father	_____	____________________	____________________
Mother	_____	____________________	____________________
Siblings	_____	____________________	____________________
	_____	____________________	____________________
Spouse	_____	____________________	____________________
Children	_____	____________________	____________________
	_____	____________________	____________________
	_____	____________________	____________________
	_____	____________________	____________________

Any Cancer in your family? If so, please list: ____

____

6. Performance Status (circle one): You are:

0 --able to carry on all pre-disease activities without restrictions.

1-- able to perform most physical activities, e.g. light house or office work, but not strenuous ones.

2—up and moving around for >50% of waking hours; able to self-care but not any work activities.

3—Confined to bed or chair for >50% of waking hours. Capable of only limited self-care.

4---Can not carry out self-care. Totally confined to bed or chair

PLEASE ANSWER ALL QUESTIONS

Please check any of the following that you have experienced during <u>the past three months</u>:

CONSTITUTIONAL
- Night sweat…………………………….. ☐
- Recent weight loss…………………………. ☐
- Fever/chills…………………………………….. ☐
- Fatigue………………………………………… ☐
- Headaches……………………………………... ☐

EYES
- Eye disease or injury………………………….. ☐
- Wear glasses/contact lens…………………….. ☐
- Blurred or double vision……………………… ☐
- Glaucoma……………………………………... ☐

ENT
- Hearing loss…………………………………... ☐
- Ringing in the ears……………………………. ☐
- Earaches or drainage………………………….. ☐
- Sinus problems………………………………... ☐
- Nose bleeds…………………………………… ☐
- Mouth sores…………………………………… ☐
- Bleeding gums………………………………… ☐
- Bad breath or bad taste………………………... ☐
- Sore throat or voice change……………………. ☐
- Swollen glands in neck………………………… ☐

CARDIOVASCULAR
- Heart trouble…………………………………… ☐
- Chest pains…………………………………….. ☐
- Sudden heart beat changes…………………….. ☐
- Swelling of feet, ankles or hands……………… ☐

RESPIRATORY
- Frequent coughing…………………………….. ☐
- Spitting up blood………………………………. ☐
- Shortness of breath…………………………….. ☐
- Asthma or wheezing…………………………… ☐

GASTROINTESTINAL
- Loss of appetite………………………………… ☐
- Nausea or vomiting……………………………. ☐
- Stomach pain…………………………………… ☐
- Change in bowel habits……..………………….. ☐
- Frequent diarrhea………………………………. ☐
- Frequent constipation………………………….. ☐
- Blood in stool or dark stool…………………….. ☐

GENITOURINARY
- Frequent urination……………………………… ☐
- Burning or painful urination…………………… ☐
- Blood in urine………………………………….. ☐
- Change of force of strain when urinating……… ☐
- Incontinence or dribbling………………………. ☐
- Kidney stones………………………………….. ☐
- Sexual difficulty……………………………….. ☐
- Male – testicle pain…………………………….. ☐
- Female – vaginal discharge…………………….. ☐
- Female – # pregnancies _____ # miscarriages ______
- Female – date of last pap smear ___________________
- Female – findings of last pap smear ❏ Normal ❏ Abnormal
- Female—date of last menses_________________

MUSCULOSKELETAL
- Joint pain………………………………………… ☐
- Joint stiffness or swelling……………………… ☐
- Weakness of muscles or joints………………… ☐
- Muscle pain or cramps………………………… ☐
- Back pain………………………………………. ☐
- Cold extremities……………………………….. ☐
- Difficulty in walking…………………………… ☐

SKIN
- Rash or itching…………………………………. ☐
- Varicose veins………………………………….. ☐
- Breast pain……………………………………… ☐
- Breast lump…………………………………….. ☐
- Breast discharge………………………………… ☐

NEUROLOGICAL
- Frequent or recurring headaches………………... ☐
- Light headed or dizzy…………………………... ☐
- Convulsions or seizures………………………… ☐
- Numbness or tingling sensations……………….. ☐
- Tremors………………………………………… ☐
- Paralysis………………………………………... ☐
- Stroke…………………………………………… ☐
- Head injury……………………………………… ☐

PSYCHIATRIC
- Memory loss or confusion……………………… ☐
- Nervousness……………………………………. ☐
- Depression……………………………………… ☐
- Sleep problems…………………………………. ☐

ENDOCRINE
- Grandular or hormone problem………………… ☐
- Excessive thirst or urination…………………… ☐
- Heat or cold intolerance……………………….. ☐
- Change in hat or glove size……………………. ☐

HEMATOLOGIC/LYMPHATIC
- Slow to heal after cuts…………………………. ☐
- Easily bruise or bleed………………………….. ☐
- Anemia…………………………………………. ☐
- Phlebitis………………………………………… ☐
- Past transfusion………………………………… ☐
- Enlarged glands………………………………… ☐

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reactions to:
- Penicillin or other antibiotics………… ☐
- Morphine, Demerol or other narcotics.. ☐
- Aspirin or other pain remedies………. ☐
- Iodine, methiolate or other antiseptic… ☐

Other drugs/medications ______________________________

Known food allergies _________________________________

Patient Signature: _______________________________________
Date: ______________________

Physician Signature: ____
Date: ____________________

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