WELCOME TO OUR CLINIC!

Patient: _____ **DOB:** ____/_____/____ **Gender Orient: M F X Date**: _____
Chief Complaint: _____

History of Present Illness:

Location: _____ **Quality:** _____
(Where is the pain/problem)? (Example; normal versus abnormal color, activity)
Severity: _____ **Duration:** _____
(How severe is the pain, 1-5, 5 most severe) (When did problem start)?
Timing: _____ **Context:** _____
(Does the pain/prob occur at a specific time)? (Where we you at the onset of this pain/problem)?
Associated Symptoms: _____ **Modifying Factors:** _____
_____ _____
(Are there any other issues you have been experiencing)? (Does anything make the problem worse or better)?

Past Medical History: (Have you ever had any of the following)? Circle "YES" or "NO", leave blank if uncertain

Measles.....NO YES	Anemia.....NO YES	Back Trouble.....NO YES	Hepatitis .....NO YES
Mumps.....NO YES	Bladder Infect ...NO YES	High Blood Pressure ..NO YES	Ulcer.....NO YES
Chickenpox ..... NO YES	Epilepsy ..... NO YES	Low Blood Pressure ...NO YES	Kidney Disease .....NO YES
Whooping Cough NO YES	Hemorrhoids.....NO YES	Thyroid Disease .....NO YES	Migraine/Headaches.NO YES
Scarlet Fever .....NO YES	Tuberculosis .....NO YES	Bleeding Tendency ....NO YES	Date of last chest Xray _____
Diphtheria .....NO YES	Diabetes .....NO YES	Asthma .....NO YES	Any other disease: _____
Smallpox .....NO YES	Cancer.....NO YES	Hives/Eczema.....NO YES	_____
Pneumonia .....NO YES	Polio ..... NO YES	AIDS/HIV>> .....NO YES	_____
Rheumatic Fever ..NO YES	Glaucoma .....NO YES	Infectious Mono.....NO YES	_____
Heart Disease .....NO YES	Hernia .....NO YES	Bronchitis .....NO YES	_____
Arthritis .....NO YES	Blood or Plasma	Mitral Valve Prolapse NO YES	_____
Venereal Disease...NO YES	Transfusion .....NO YES	Stroke.....NO YES	_____

Previous Hospitalizations/Surgeries/Serious Illnesses:	**When?**	**Hospital, City, State**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (Including Non-prescription)

_____
_____

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/day:_____**	
Use of Recreational Drugs:	**Never:_____**	**Previously, but quit:_____**			
Excessive Exposure to:	**Fumes:_____**	**Dust:_____**	**Solvents:_____**	**Airborne Particles:_____**	**Noise:_____**

Family Medical History:

Relationship	**Age**	**Diseases**	**If deceased, cause of death**
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
Grandmother:	_____	_____	_____
Grandfather:	_____	_____	_____
Children:	_____	_____	_____