

INITIAL HISTORY FORM

Name _____ Age _____ D.O.B. _____

Reason for Visit _____ Duration _____ Today's Date _____

PLEASE CHECK THE PROBLEMS THAT APPLY TO YOU (No checks mean no problems)

REVIEW OF SYSTEMS

- | | | | | |
|----------------------|--|---|--|--|
| Constitutional: | <input type="checkbox"/> fever | <input type="checkbox"/> chill | | |
| Eyes: | <input type="checkbox"/> excessive tearing | <input type="checkbox"/> itchy eyes | | |
| Cardiovascular: | <input type="checkbox"/> irregular heart | <input type="checkbox"/> syncope(fainting) | <input type="checkbox"/> lightheadedness | <input type="checkbox"/> high blood pressure |
| Respiratory: | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> wheezing | <input type="checkbox"/> cough | <input type="checkbox"/> coughing up blood |
| Gastrointestinal: | <input type="checkbox"/> heart burn | <input type="checkbox"/> irritable bowel | | |
| Genitourinary: | <input type="checkbox"/> Urinary hesitancy | <input type="checkbox"/> prostate trouble | | |
| Integument: | <input type="checkbox"/> skin rash | <input type="checkbox"/> itching skin | | |
| Neurologic: | <input type="checkbox"/> incoordination | <input type="checkbox"/> tingling / numbness | <input type="checkbox"/> loss of balance | <input type="checkbox"/> loss of consciousness |
| Musculoskeletal: | <input type="checkbox"/> joint pain | <input type="checkbox"/> limitation of motion | <input type="checkbox"/> muscular weakness | |
| Psychiatric: | <input type="checkbox"/> anxiety | <input type="checkbox"/> depression | | |
| Heme-Lymph: | <input type="checkbox"/> easy bleeding | <input type="checkbox"/> easy bruising | | |
| Allergic-Immunology: | <input type="checkbox"/> allergic dermatitis | <input type="checkbox"/> frequent illness | | |

PATIENT HISTORY:

- | | |
|-------------------|-----------------------------|
| _____ Glaucoma | _____ High Blood Pressure |
| _____ Seizures | _____ Heart Attack |
| _____ Arthritis | _____ Heart Failure |
| _____ Asthma | _____ Stroke |
| _____ Ulcers | _____ Mitral Valve Prolapse |
| _____ Hepatitis | _____ Rheumatic Fever |
| _____ Diabetes | _____ Kidney/Bladder |
| _____ Thyroid | _____ Migraine |
| _____ Other _____ | |

PERSONAL HISTORY:

Tobacco Use: _____ Yes _____ No
How Often _____ Amount Used _____
Age Started _____ Age Stopped _____

Alcohol Use: _____ Yes _____ No
How Often _____ Amount Consumed _____
Age Started _____ Age Stopped _____

Check box if any of these apply to patient

- Exposure to second hand smoke?
- Exposure to tobacco smoke in the perinatal period?
- History of tobacco use?
- Exposure to smoke at work?
- Tobacco dependence?
- Tobacco use?

PREVIOUS SURGERY: (List ALL Surgery) _____

FAMILY HISTORY:

- _____ Hearing Loss
- _____ Allergy
- _____ Heart Disease/Blood Pressure
- _____ Cancer
- _____ Anesthesia Problem
- _____ Bleeding Disorders
- _____ Muscular Dystrophy
- _____ Other _____

MEDICATIONS NOW TAKING: (including Aspirin or over-the-counter medicines)

Type & Date: _____

Mother Alive _____ Deceased _____
Cause _____
Father Alive _____ Deceased _____
Cause _____

OCCUPATION: _____

PHARMACY OF CHOICE: _____

Are you receiving any Hospice or Home Health Care?
_____ Yes _____ No

DRUG ALLERGIES: _____

Updated _____ Updated _____
Updated _____ Updated _____

FAMILY PHYSICIAN: _____

REFERRING PHYSICIAN: _____