

Patient: _____ New Patient Info. Form Ht: _____ Wt: _____ Temp: _____
 Date: _____ Family Dr.: _____ BP: _____ / _____ Pulse: _____
 Occupation: _____ Pharmacy #: _____

HISTORY

CHIEF COMPLAINT: _____

HISTORY of PRESENT ILLNESS: For an "Extended history, document at least 4 of these elements

- **Location** _____
(Where is the pain/problem?)
- **Quality** _____
(Example: color of sputum?)
- **Severity** _____
(How severe is the pain/problem)
- **Duration** _____
(How long have you had this pain/problem? or When did it start?)
- **Timing** _____
(Does this pain/problem occur at a specific time?)
- **Context** _____
(Where were you at the onset of this pain/problem?)
- **Associated signs/symptoms** _____
(What other associated problems have you been having?)
- **Modifying factors** _____
(What makes the pain/problem worse or better? ...or... Have you had any previous episodes?)

MEDICAL HISTORY:

- For a "Pertinent" history - at least 1 specific item for ANY ONE of the 3 histories
- For a "Complete" history - at least 1 specific item for EACH ONE of the 3 histories

Patient medical history

Diabetes	No	Yes	Previous Hospitalizations/Surgeries/Serious Injuries	When?
Hypertension	No	Yes	_____	_____
Cancer	No	Yes	_____	_____
Stroke	No	Yes	_____	_____
Heart Trouble	No	Yes	_____	_____
Arthritis/gout	No	Yes	_____	_____
Convulsions	No	Yes	Medications	_____
Bleeding tendency	No	Yes	_____	_____
Acute infections	No	Yes	_____	_____
Venereal disease	No	Yes	_____	_____
Hereditary defects	No	Yes	_____	_____

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 drugs: Never ___ Type/Frequency _____
 Excessive exposure at home or work to: Fumes ___ Dust ___ Solvents ___ Air-borne particles ___ Noise ___

Family medical history

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

• CONSTITUTIONAL SYMPTOMS

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

• EYES

Eye disease or injury	No	Yes
Wear glasses/contact lens	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

• EAR/NOSE/MOUTH/THROAT

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

• CARDIOVASCULAR

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath with walking or lying down	No	Yes
Swelling of feet, ankles or hands	No	Yes

• RESPIRATORY

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

• GASTROINTESTINAL

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain or heartburn	No	Yes
Peptic ulcer (stomach or duodenal)	No	Yes

• GENITOURINARY

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male - testicle pain	No	Yes
Female - pain with periods	No	Yes
Female - irregular periods	No	Yes
Female - vaginal discharge	No	Yes
Female - number of pregnancies _____ # miscarriages _____		
Female - date of last pap smear _____		

• MUSCULOSKELETAL

Joint Pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

• INTEGUMENTARY (skin, breast)

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast pump	No	Yes
Breast discharge	No	Yes

• NEUROLOGICAL

Frequent or recurring headaches	No	Yes
Light-headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes

• PSYCHIATRIC

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

• ENDOCRINE

Glandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

• HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

• ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:		
Penicillin or other antibiotics	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Novocaine or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, merthiolate or other antiseptic	No	Yes
Other drugs/medications _____		
Know food allergies _____		