

Comprehensive Patient History Form

Patient Name:		Date of Birth:	Age:	Date:
Race:		Referring MD:		
**		for your visiting:		
How long have	e you had this	problem?		
2. Have you ever	r had the follo	owing?		
Diabetes		Hypertension	Cancer Arthritis/gout Acute infections Kidney trouble	
		ons/Surgeries/Serious Injuries		List all allergies you have ever had 1)
		Married □ Separated □ Divorced	□ Widowed	
Use of alcohol:	\square Never \square	Rarely Moderate Daily		
Use of tobacco:	\square Never \square	Previously but quit Current packs	per day	
Occupation:	present	; Past		
5. Family Medic	cal History Age	<u>Diseases</u>		If Deceased, Age and Cause
Father				
Mother				
Siblings				
Spouse				
Children				
Any cancer in yo	our family? If	so, please list:		
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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 the past three months:

CONSTITUTIONAL		MUSCULOSKELETAL
Night sweat		Joint pain
Recent weight loss		Joint stiffness or swelling
Fever/chills		Weakness of muscles or joints
Fatigue		Muscle pain or cramps
Headaches		Back pain
		Cold extremities.
EYES		Difficulty in walking
Eye disease or injury		•
Wear glasses/contact lens		SKIN
Blurred or double vision		Rash or itching
Glaucoma		Varicose veins
		Breast pain
ENT		Breast lump
Hearing loss		Breast discharge
Ringing in the ears		NEUROLOGICAL
Earaches or drainage		
		Frequent or recurring headaches
Sinus problems		Light headed or dizzy
Nose bleeds		Convulsions or seizures
Mouth sores		Numbness or tingling sensations
Bleeding gums		Tremors
Bad breath or bad taste		Paralysis
Sore throat or voice change		Stroke
Swollen glands in neck		Head injury
CARDIOVASCULAR		PSYCHIATRIC
Heart trouble		
		Memory loss or confusion
Chest pains		Nervousness
Sudden heart beat changes		Depression
Swelling of feet, ankles or hands		Sleep problems
RESPIRATORY Frequent coughing	П	ENDOCRINE Grandular or hormone problem
Spitting up blood		Excessive thirst or urination
Shortness of breath		Heat or cold intolerance
Asthma or wheezing		Change in hat or glove size
GASTROINTESTINAL		HEMATOLOGIC/LYMPHATIC
Loss of appetite		Slow to heal after cuts
Nausea or vomiting		Easily bruise or bleed
Stomach pain		Anemia
Change in bowel habits		Phlebitis
Frequent diarrhea		Past transfusion
Frequent constipation		Enlarged glands
Blood in stool or dark stool		
27000 III 50001 OF GREEK 51001		ALLERGIC/IMMUNOLOGIC
GENITOURINARY		History of skin reaction or other adverse reactions to:
Frequent urination		
		Penicillin or other antibiotics
Burning or painful urination		Morphine, Demerol or other narcotics \Box
Blood in urine		Aspirin or other pain remedies
Change of force of strain when urinating		Iodine, methiolate or other antiseptic □
Incontinence or dribbling		Other drugs/medications
		Known food allergies
Kidney stones		Miowii iood alicigics
Sexual difficulty		
Male – testicle pain		
Female – vaginal discharge		
Female – date of last pap smear		
Female – date of last pap smear Normal	☐ Abnormal	
Female – # pregnancies # miscarriages _ Female – date of last pap smear Pemale – findings of last pap smear Normal Female—date of last menses Signature:	□ Abnormal	Physician Signature: