Comprehensive History Form

Name________________________________ **Age**______ **DOB:**_____/______/______
Name of your primary care physician____
Review of Systems: (Check any of the following that you have, or have had in the past)

☐ Weight Loss
☐ Weight Gain
☐ Fatigue
☐ Blurry Vision
☐ Double Vision
☐ Ringing in ears
☐ Hearing Loss
☐ Sinus Congestion
☐ Bloody Nose
☐ Loss of Taste
☐ Dry Mouth
☐ Sore Throat
☐ Chest Pain
☐ Irregular Heartbeat
☐ Shortness of Breath
☐ Trouble Breathing
☐ Cough
☐ Upset Stomach
☐ Diarrhea
☐ Bloody Stools
☐ Frequent Urination
☐ Burning with Urination
☐ Joint Pain
☐ Joint Stiffness
☐ Muscle Weakness
☐ Rashes
☐ Sores
☐ Numbness
☐ Poor Balance
☐ Anxiety
☐ Depression
☐ Hair Loss
☐ Excessive Thirst
☐ Easy Bruising
☐ Food Allergies
☐ Seasonal Allergies

None of the above please initial here__________________(NONE)

Past Medical History:

Ulcers	Yes or No
Diabetes	Yes or No
Heart Disease	Yes or No
Circulation Problems	Yes or No
Kidney Disease	Yes or No
High Blood Pressure	Yes or No
Cancer	Yes or No
Lung Disease	Yes or No
Thyroid Disease	Yes or No

Other_________________________

Previous Surgery(s):

1________________________________

2________________________________

3________________________________

4________________________________

Medications: (List Dose and How Often)

1____________________________________

2____________________________________

3____________________________________

4____________________________________

5____________________________________

6____________________________________

7____________________________________

8____________________________________

9____________________________________

10____________________________________

Allergies:

1____________________________________ 2____________________________________

3____________________________________ 4____________________________________

History of Previous Wounds/Injuries:

____

____

Family History:

Does Anyone in Your Family Have a History of:

		Family Member:
High Blood Pressure	Yes or No	________________________
Diabetes	Yes or No	________________________
Heart Disease	Yes or No	________________________
Cancer	Yes or No	________________________

Is your father: Living or Deceased Cause of Death___________________________

Is your mother: Living or Deceased Cause of Death___________________________

Number of brothers_______ Number Deceased________ Cause of Death____________

Number of sisters ________ Number Deceased________ Cause of Death____________

Social History:

Marital Status: Single Married Divorced Widowed

Live Alone?: Yes or No

Occupation:____

Do you smoke? Yes or No If yes, how much?_________ How many years?__________

Do you drink alcohol? Yes or No If yes, how much?______________________________

Do you use recreational drugs? Yes or No

Do you exercise? Never Rarely Regularly

Patient Signature____ Date________________

Reviewed and Updated By: _______ MD Date_________ _________MD Date_________

_______ MD Date_________ _________MD Date_________

(Please initial) **_______ MD Date_________ _________MD Date_________**

_______ MD Date_________ _________MD Date_________

_______ MD Date_________ _________MD Date_________

_______ MD Date_________ _________MD Date_________

Comprehensive History Form (Continued)

Name_________________________________ **Date completed**_______________________

Reviewed and Updated By: ________ **MD Date**__________ __________**MD Date**__________
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