PATIENT HISTORY FORM

Date____/____/____ **Date of last physical exam** ____/____/____

First Name:_____ **Last Name:**_____ **Middle:**_____

What is the main reason for your visit today? (describe in detail)

_____

HISTORY OF PRESENT ILLNESS:

Location of problem:_____ **How long does problem last:**_____

How severe is the problem:_____ **Is it constant : YES NO**

Is it intermittent: YES NO

SOCIAL HISTORY:

Marital Status (circle one): Single Married Divorced Widow

Number of children:_____

Smoke: _____ **Quantity**_____

Alcohol:_____ **Quantity**_____

Religion:_____

Medical Family History (diseases)

Father:_____

Mother:_____

Siblings:_____

GYNECOLOGICAL HISTORY:

Age at onset of menses:_____ **Date of last papsmear:**_____

Number of pregancies:_____ **Age at onset of menopause**_____

HISTORY OF PAST ILLNESSES:

Date: Illness:

SURGERY:

Date: Surgery:

MEDICATIONS:

ALLERGIES:

ADVANCE DIRECTIVE GIVEN TO PATIENT? Y N

EMPLOYEE INITIALS:_____