

Comprehensive History

Name: _____ Birthdate: _____ Age: _____ Date: _____

Review of systems: (Circle all current symptoms)

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

Past Medical History:

Diabetes	_____	Previous Surgeries:	_____
Rheumatoid Arthritis	_____		_____
Circulation Problems	_____		_____
High Blood Pressure	_____		_____
Cancer	_____		_____
Asthma	_____		_____
Other	_____		_____
_____		Pacemaker ()	_____
_____		Heart Defibulator	_____

Medications: (List Dose and How Many)	_____	Allergies:	_____
_____			_____
_____			_____
_____			_____

Family History:

Does anyone in your family have: High Blood Pressure Diabetes Heart Disease Stroke Cancer

Father	Living / Deceased	Cause of Death:	_____
Mother	Living / Deceased	Cause of Death:	_____
Brother	Living / Deceased	Cause of Death:	_____
Sister	Living / Deceased	Cause of Death:	_____

Social History:

Marital Status:	Single	Married	Divorced	Widowed
Live Alone?	Yes / No			
Occupation:	_____			
Smoke?	Yes / No	If Yes, how many per day?		_____
		How many years?		_____
Drink?	Yes / No	If Yes, how much do you drink?		_____
Pharmacy Used:	_____			

Patient Signature: _____ Date: _____

Reviewed By:	_____	MD	Date:	_____
Reviewed By:	_____	MD	Date:	_____
Reviewed By:	_____	MD	Date:	_____

Revised: _____