General Patient Medical History Form

Name: _____ MRN: _____ Today's Date: _____

1. History of Present Illness

What is the problem you are being seen for today? _____

_____

Location of pain: _____

Severity of pain on a scale of 1 (little or no pain) to 10 (severe pain): _____ _____

Duration (how long have you had the pain): _____

Associated signs/symptoms: _____

2. Please list all prior hospitalizations and surgeries:

Year	Operation/Illness	Year	Operation/Illness

3. List all medications you are now taking or have taken in the last two weeks:

Medicine	Dose/Times per day	Reason for Taking

4. Please list any allergies to medicines, food, x-ray dyes, environmental items, adhesive tapes, latex:
(Example: Penicillin, causes a rash, eggs cause hives, pollen causes sneezing.)
No known allergies ☐ (check here if you have no known allergies)

Allergy	Reaction

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5. Height: _____ Weight: _____ Age: _____

6. Past Medical History:

Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Strokes	☐ Yes	☐ No	Seizure Disorder	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No	Congestive Heart Failure	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No	Have you ever had a heart cath or stress test?	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Other:		

9. Do you use any special breathing equipment at home? ☐ Yes ☐ No
If yes, ☐ Nebulizer ☐ Inhalers ☐ Oxygen ☐ Breathing treatments ☐ CPAP

10. Do you have a history of TB? ☐ Yes ☐ No
Have you been exposed to TB? ☐ Yes ☐ No
Date of exposure: _____
History of TB skin test: ☐ positive ☐ negative ☐ unknown
Date of skin test (approx): _____

13. Do you use tobacco? ☐ No ☐ Pipe ☐ Cigar ☐ Chew ☐ Quit Date quit: _____
Do you smoke? ☐ Yes ☐ No
How many packs per day? _____ For how many years? _____

14. Do you drink alcohol? ☐ Yes ☐ No
If yes, how much? _____ How often? _____
Date of last drink? _____

16. Are you currently employed? ☐ Yes ☐ No If yes, what is your occupation: _____
If no, what kind of work have you done in the past? _____
Does your job require manual labor activities? ☐ Yes ☐ No If yes, please describe: _____

17. Do you have allergy to latex? ☐ Yes ☐ No
Do you have an implanted cardiac device? ☐ Yes ☐ No
Do you have any problems with your vision? ☐ Yes ☐ No Vision aids used: Glasses Contact Lenses
Do you have any problems with your hearing? ☐ Yes ☐ No Hearing aids used: _____
Do you have problems with (check all that apply) ☐ Taste ☐ Touch/Feel ☐ Smell

Form completed by: _____ Date: _____

If other than the patient, please identify the relationship: _____

Reviewed by: _____ Title: _____ Date: _____