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History of Present Illness

Chief Complaint: _____

Part(s) of body affected:_____Onset of symptoms: _____

Are symptoms: ☐ Slight ☐ Moderate ☐ Severe ☐ Constant ☐ Come and go

Medications taken for this: _____

Allergies: **Are you allergic to any medicine? Y N If yes, what medications?** _____

PAST HISTORY OF MAJOR MEDICAL PROBLEMS			
PROBLEM	**YEAR**	**PROBLEM**	**YEAR**
☐ Diabetes		☐ High Cholesterol	
☐ High blood pressure		☐ High Triglyceride	
☐ Heart problems		☐ Stroke	
☐ Heart failure		☐ Peptic Ulcers	
☐ Heart attack		☐ Hearing loss	
☐ Murmur		☐ Growths in colon	
☐ Valve problems		☐ Hemorrhoids	
☐ Emphysema		☐ Whip-lash	
☐ Arthritis		☐ Concussion	
☐ Asthma		☐ Meningitis	
☐ Thyroid problems		☐ Scarlet fever	
☐ Epilepsy		☐ Pancreatitis	
☐ Migraines		☐ Perpetual sinus	
☐ Gout		☐ Blood clot in lung	
☐ Hypoglycemia			
☐ Back problems: Which activities are limited?			
☐ Phlebitis: Which leg?		Year:	
Any other medical problems?			

LIST OF DAILY MEDICATIONS	
Name & Dosage	**Directions**

Name:_____**Date**: _____

SURGERIES	
Type	**Date**

If you have you been hospitalized within the last 10 years, list date(s) and reason(s) for your stay? _____

Have you ever broken any bones? ☐ Yes ☐ No If yes, what bones? _____

_____When? _____

FAMILY HISTORIES *Include parents, siblings, grandparents, aunt or uncles*	
Type	**Family member**
☐ Diabetes	
☐ Coronary or Heart Disease	
☐ High blood pressure	
☐ Breast cancer	
☐ Colon cancer	

If any member of your family had any other type of cancer, please state where in the body the original lesion was:_____

_____

SOCIAL HISTORY

(Circle Y or N)

Y N Do you smoke? If yes, what do you smoke?_____For how long?_____Packs per day: _____

Y N Do you drink? If yes, how much do you drink?_____ How often?_____

Y N Do you use illegal drugs? If yes, what type?_____

Y N Are you now, or have you ever been exposed to toxic substances at work? If yes, type?_____

Y N Do you have breast implants? **Y N** Any other implants? If yes, what type?_____

What is your occupation?_____

Name:_____Date: _____

GLAND (ENDOCRINE) PROBLEM		
☐ Thyroid problems	☐ Colder/hotter than everyone	☐ No problems
☐ Jittery	☐ More thirsty than usual	
☐ Frequent urination	☐ Yes, but no change	
HEAD AND EYES		
☐ Headaches	☐ Cataracts	☐ No problems
☐ Vision change	☐ Yes, but no change	
EARS, NOSE AND THROAT		
☐ Hearing change	☐ Fever blisters	☐ Dental surgery
☐ Ear Infection	☐ Yeast infection	☐ Toothache
☐ Soreness	☐ Swallowing problems	☐ Yes, but no change
☐ Sinus problems	☐ Nose bleed	☐ No problems
☐ Cold sores	☐ Ulcers	
UPPER G.I.		
☐ Indigestion	☐ Nausea	☐ Yes, but no change
☐ Acid reflux	☐ Vomiting	☐ No problems
☐ Reflex	☐ Can't drink milk	
☐ Gallbladder	☐ Other	
LOWER G.I.		
☐ Constipation	☐ Dark black (tar like) stool	☐ Yes, but no change
☐ Blood in stool	☐ Watery	☐ No problems
☐ Fissures	☐ Soft	
☐ Diarrhea	☐ Hemorrhoids	
LUNGS		
☐ Short of breath at rest	☐ Smoking	☐ Mucus
☐ Short of breath on exertion	☐ Tuberculosis	☐ Yes, but no change
☐ Wheezing	☐ Cough	☐ No problems
HEART		
☐ Rhythm fast	☐ Must sleep sitting up	☐ Feet of legs swelling
☐ Rhythm slow	☐ Chest pain sitting	☐ Yes, but no change
☐ Irregular	☐ Chest pain on exertion	☐ No problems
BREAST		
☐ Soreness	☐ Lump in armpit	☐ Yes, but no change
☐ New lump	☐ Soreness	☐ No problems
☐ Can't move arm normally	☐ Redness	
☐ Arm swelling	☐ Swelling	
BLADDER		
☐ Urine burns	☐ Hard to start urine	☐ Color change
☐ Urine infection	☐ Have to get up at night	☐ Yes, but no change
☐ Blood in urine	☐ Go frequently	☐ No problems
☐ Hard to stop urine	☐ Loose control	
VAGINA		
☐ Yeast	☐ Dryness	☐ Yes, but no change
☐ Bleeding	☐ Odor	☐ No problems
☐ Discharge	☐ Taking Tamoxifen	
Still having periods? ☐ Yes ☐ No	Last period?	Last pelvic exam?
Date of last pap?	Date of last mammogram?	

Name:_____ **Date:** _____

SKIN/HAIR/NAILS		
☐ Skin rashes	☐ Hair loss	☐ No problems
☐ Itching	☐ Toenail changes	
☐ Moles or sores	☐ Yes, but no change	
MSCLES/JOINTS/BONES		
☐ Muscle pain	☐ Back pair	☐ No problems
☐ Bone pain	☐ Arthritis	
☐ Joint pain	☐ Yes, but no change	
NERVOUS SYSTEM		
☐ Numbness	☐ Speech problems	☐ Fainting
☐ Tingling	☐ Confusion	☐ Yes, but no change
☐ Muscle weakness	☐ Forgetfulness	☐ No problems
EMOTIONAL		
☐ Coping	☐ Can't sleep	☐ Feel guilty
☐ Not coping	☐ Sleep to much	☐ Tired all the time
☐ Anxious	☐ Eat when stressed	☐ Problems with sex
☐ Depressed	☐ Eat too much/little	☐ Yes, but no change
☐ Not having any fun	☐ Crying	☐ No problems

Patient Name:		
Date:	Time:	☐ A.M. ☐ P.M.
Responsible Party Name:		
Date:	Time:	☐ A.M. ☐ P.M.