

**History of Present Illness**

**Patient Name:** \_\_\_\_\_

Why are we seeing you today? \_\_\_\_\_

Duration of Problem and Symptoms \_\_\_\_\_

Location of Problem \_\_\_\_\_

On a scale of 1-10 with 10 being the most severe, circle the number that best describes the severity of the problem:

1      2      3      4      5      6      7      8      9      10

How long does the problem last? Minutes? Hours? Days? Years? \_\_\_\_\_

Are there any associated problems? \_\_\_\_\_

Does the problem interfere with your daily or work activities? \_\_\_\_\_

Does anything make the problem better or worse? \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Any recent unexplained weight gain or loss? \_\_\_\_\_

In addition to the above, have you had or are you currently having difficulty with any of the following? Check all that apply.

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Heart Murmur       | <input type="checkbox"/> Depression               |
| <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Emphysema/COPD           | <input type="checkbox"/> Heart Attack       | <input type="checkbox"/> Liver Problems           |
| <input type="checkbox"/> TB                   | <input type="checkbox"/> Pneumonia                | <input type="checkbox"/> Stroke             | <input type="checkbox"/> Mitral Valve Prolapse    |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Thyroid Problems         | <input type="checkbox"/> Spinal Cord Injury | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> Epilepsy/Seizures    | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Glaucoma                 |
| <input type="checkbox"/> Gout                 | <input type="checkbox"/> Blood Clots              | <input type="checkbox"/> Ulcers             | <input type="checkbox"/> Back Problems            |
| <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Kidney Stones      | <input type="checkbox"/> Endometriosis            |
| <input type="checkbox"/> Other _____          |   |   |   |

Please list all of your medications:  None \_\_\_\_\_

Please list any DRUG ALLERGIES or Food Allergies:  None \_\_\_\_\_

Previous Surgeries (with dates): \_\_\_\_\_

Do you smoke currently?  Yes  No How Much? \_\_\_\_\_

Did you smoke in the past?  Yes  No

Do you drink alcohol?  Yes  No How Often? \_\_\_\_\_

Do you use recreational or illegal drugs?  Yes  No

**Family History**

Patient Name: \_\_\_\_\_

Mother:  Living  Deceased If deceased, cause of death: \_\_\_\_\_Father:  Living  Deceased If deceased, cause of death: \_\_\_\_\_

Please check if anyone in your family has or has had problems with any of the following:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Kidney stones           | <input type="checkbox"/> Bladder cancer  |
| <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Urinary tract problems  | <input type="checkbox"/> Kidney cancer   |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney problems/failure | <input type="checkbox"/> Prostate cancer |
| <input type="checkbox"/> Blood clots         | <input type="checkbox"/> Prostate problems       | <input type="checkbox"/> Other cancer    |

IF FEMALE: How many pregnancies? \_\_\_\_\_ Vaginal  C-section 

Date of last Menstrual Period: \_\_\_\_\_

**Are you currently having any problems with any of the following: (Please check the appropriate boxes)****Constitutional:**

- Fever/Chills
- Night sweats
- Headaches
- Weight gain or loss

**Eyes:**

- Recent changes in vision
- Glaucoma

**Ears, Nose and Throat:**

- Hearing loss
- Difficulty speaking
- Sore throat/hoarseness
- Nose bleeds

**Cardiovascular:**

- Chest pain
- High blood pressure
- Pacemaker
- Poor circulation
- Swollen ankles or feet
- Irregular heart beat

**Nutritional:**

- Loss of appetite
- Difficulty swallowing
- Tube feedings at home
- Hyperalimentation at home

**Respiratory:**

- Shortness of breath
- Wheezing
- Recent or frequent bronchitis/colds

**Gastrointestinal:**

- Hemorrhoids
- Constipation
- Diarrhea
- Blood in your stools
- Nausea and/or vomiting
- Abdominal pain
- Irritable bowel syndrome

**Musculoskeletal:**

- Back pain
- Arthritis
- Neck pain

**Neurological:**

- Tremors
- Seizures
- Numbness or tingling
- Spinal cord injury Level \_\_\_\_\_

**Psychiatric:**

- Depression
- Anxiety
- Schizophrenia
- Bipolar disorder
- Other: \_\_\_\_\_

**Genitourinary:**

- Burning with urination
- Urge to void suddenly
- Getting up at night to urinate
- Frequent urination
- Blood in urine
- Slow or intermittent stream
- Pain in area of bladder
- Problems with erections
- Pain with intercourse
- Frequent urine infections
- Pressure in pelvic area
- Leakage of urine

**Hematologic:**

- Easy bruising or bleeding
- Swollen glands or lymph nodes

**Allergic/Immunologic:**

- Hay fever
- Food allergies
- medication allergies

**Endocrine:**

- Excessive thirst
- Too hot/cold frequently
- Excessive fatigue