



Comprehensive Patient History Form

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Internal Medicine

Patient Name: _____ DOB: _____ Occupation: _____ Date: _____

Describe your main problem _____

Where is your problem located? _____

How severe is your problem? _____

How long have you had this problem? _____

When does this problem occur? _____

Where were you when this problem started? _____

What other things happen with this problem? _____

List previous hospitalizations/Surgeries/Serious Injuries/Illness When?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Social History

Marital Status: Single Married Separated Divorced Widowed

Use of alcohol: Never Rarely Moderate Daily _____

Use of tobacco: Never Previously but quit Current packs per day _____

Use of Drugs: Never Type/Frequency _____

Excessive exposure at home/work Fumes Dust Solvents Noise Smoke

With whom do you live? _____

Family Medical History

	<u>Age</u>	<u>Diseases</u>	<u>If Deceased, Cause of Death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Have you ever had the following?		
Anemia.....	yes	no
Asthma.....	yes	no
Diabetes.....	yes	no
Hypertension.....	yes	no
Cancer.....	yes	no
Stroke.....	yes	no
Heart trouble.....	yes	no
Arthritis/gout.....	yes	no
Convulsions.....	yes	no
Bleeding tendency.....	yes	no
Acute infections.....	yes	no
Venereal disease.....	yes	no
Hereditary defects.....	yes	no
Thyroid problems.....	yes	no
Kidney disease.....	yes	no

List Medications you are currently taking

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____
- 8) _____
- 9) _____
- 10) _____

Family History		
IF YES LIST	RELATIONSHIP	
Stroke	yes no	_____
Cancer	yes no	_____
Hypertension	yes no	_____
Diabetes	yes no	_____
Heart trouble	yes no	_____
Bleeding prob	yes no	_____
Asthma	yes no	_____
Anemia	yes no	_____
Convulsions	yes no	_____
Arthritis/gout	yes no	_____
Kidney disease	yes no	_____
Thyroid disease	yes no	_____
Hereditary defects	yes no	_____

PLEASE ANSWER ALL QUESTIONS

Have you had any of the following during the past three months?

CONSTITUTIONAL

Good general health lately..... No Yes
 Recent weight change..... No Yes
 Fever..... No Yes
 Fatigue..... No Yes
 Headaches..... No Yes

EYES

Eye disease or injury..... No Yes
 Wear glasses/contact lens..... No Yes
 Blurred or double vision..... No Yes
 Glaucoma..... No Yes

ENT

Hearing loss..... No Yes
 Ringing in the ears..... No Yes
 Earaches or drainage..... No Yes
 Sinus problems..... No Yes
 Nose bleeds..... No Yes
 Mouth sores..... No Yes
 Bleeding gums..... No Yes
 Bad breath or bad taste..... No Yes
 Sore throat or voice change..... No Yes
 Swollen glands in neck..... No Yes
 Difficulty swallowing..... No Yes

CARDIOVASCULAR

Heart trouble..... No Yes
 Chest pains..... No Yes
 Sudden heart beat changes..... No Yes
 Swelling of feet, ankles or hands..... No Yes

RESPIRATORY

Frequent coughing..... No Yes
 Spitting up blood..... No Yes
 Shortness of breath..... No Yes
 Asthma or wheezing..... No Yes
 Do you awaken at night with shortness of breath? No Yes

GASTROINTESTINAL

Loss of appetite..... No Yes
 Change in bowel movements..... No Yes
 Nausea or vomiting..... No Yes
 Frequent diarrhea..... No Yes
 Painful bowel movements or constipation..... No Yes
 Blood in stool..... No Yes
 Stomach pain..... No Yes

GENTOURINARY

Awaken more than once a night to urinate No Yes
 Frequent urination..... No Yes
 Burning or painful urination..... No Yes
 Blood in urine..... No Yes
 Change of force of strain when urinating..... No Yes
 Incontinence or dribbling..... No Yes
 Kidney stones..... No Yes
 Sexual difficulty..... No Yes
 Male – testicle pain..... No Yes
 Female – pain with periods..... No Yes
 Female – irregular periods..... No Yes
 Female – vaginal discharge..... No Yes
 Female – # pregnancies _____ # miscarriages _____
 Female – date of last pap smear _____
 Female – findings of last pap smear Normal Abnormal

MUSCULOSKELETAL

Joint pain..... No Yes
 Joint stiffness or swelling..... No Yes
 Weakness of muscles or joints..... No Yes
 Muscle pain or cramps..... No Yes
 Back pain..... No Yes
 Cold extremities..... No Yes
 Difficulty in walking..... No Yes

SKIN

Rash or itching..... No Yes
 Change in skin color..... No Yes
 Change in hair or nails..... No Yes
 Varicose veins..... No Yes
 Breast pain..... No Yes
 Breast lump..... No Yes
 Breast discharge..... No Yes

NEUROLOGICAL

Frequent or recurring headaches..... No Yes
 Light headed or dizzy..... No Yes
 Convulsions or seizures..... No Yes
 Numbness or tingling sensations..... No Yes
 Tremors..... No Yes
 Paralysis..... No Yes
 Stroke..... No Yes
 Head injury..... No Yes

PSYCHIATRIC

Memory loss or confusion..... No Yes
 Nervousness..... No Yes
 Depression..... No Yes
 Sleep problems..... No Yes
 Do you feel stressed..... No Yes

ENDOCRINE

Glandular or hormone problem..... No Yes
 Thyroid disease..... No Yes
 Diabetes..... No Yes
 Excessive thirst or urination..... No Yes
 Heat or cold intolerance..... No Yes
 Dry skin..... No Yes
 Change in hat or glove size..... No Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts..... No Yes
 Easily bruise or bleed..... No Yes
 Anemia..... No Yes
 Phlebitis..... No Yes
 Past transfusion..... No Yes
 Enlarged glands..... No Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reactions to:
 Penicillin or other antibiotics..... No Yes
 Morphine, Demerol or other narcotics.. No Yes
 Novocaine or other anesthetics..... No Yes
 Aspirin or other pain remedies..... No Yes
 Tetanus antitoxin or other serums..... No Yes
 Iodine, methiolate or other antiseptic... No Yes
 Other drugs/medications _____
 Known food allergies _____

Patient Signature: _____ DATE: _____

Physician Signature: _____ DATE: _____