HEALTHQUEST
Medical Practice

Comprehensive Patient History Form

Patient Name:_____ 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 When?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever had the following?

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

List Medications you are currently taking

1)_____
2)_____

3)_____
4)_____

5)_____
6)_____

7)_____
8)_____

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 or work to: ˜ Fumes ˜ Dust ˜ Solvents ˜ Noise

Health Maintenance

Last Mammogram _____ Last Colonoscopy _____

Last Prostrate Exam _____ Last Bone Density _____

Family Medical History

Age Diseases If Deceased, Cause of Death

Father _____

Mother _____

Siblings _____

_____

Spouse _____

Children _____

_____

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

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
Pain with Breathing……. 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
Black Stools……. No Yes

GENITOURINARY

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 ˇ Normal ˇ Abnormal
Change in Sexual Partners……. No Yes
History of STD's…….. No Yes

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

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: _____ Physician Signature: _____