Hendricks Regional Health Medical Group

Patient Name _____ Date of Birth _____

History of Present Illness

Why are you being seen today? _____
How long have you had this problem? _____
What are you current symptoms? _____
What tests have you had done in relation to this problem?
□ CT □ MRI □ X-ray □ Upper GI □ Colonoscopy □ Ultrasound □ HIDA scan
□ Other _____
On scale of 1-10 (0 means no pain, 10 being most severe) circle # that best describes your pain
0 1 2 3 4 5 6 7 8 9 10
Please list any previous treatments you may have received for this problem _____
_____
_____

Current Medications
Please list all medications you are taking at this time, include vitamins, supplements & herbal

Name of Drug	Dose (include strength and number of pills per day)	How long have you taken this medications?	Why do you take this medications?
1			
2			
3			
4			
5			
6			
7			
8			

Past Medical History- *Please include all medical problems such as diabetes, hypertension, etc.*
_____
_____
_____
_____

Allergies-*Please list all medications, foods, and environmental agents you are allergic to. Please include what type of reaction you have (hives, nausea, breathing problems, etc.)*
_____
_____
_____
_____

Past Surgical History- *Please list all procedures including surgeries, colonoscopies, heart catheterizations, etc.*

_____

_____

_____

_____

Hospitalizations- *Please list reasons and dates*

_____

_____

_____

_____

Family History-*Please list all major medical conditions.*

Mother _____ Father _____

Brother(s) _____

Sister(s) _____

Children _____

Grandparents _____

Social History

Marital Status _____Spouse's Name _____Children _____

Occupation _____ Hobbies/Interests _____

Tobacco use: _____ packs per day _____ for years

Alcohol use: _____

Exercise: _____

Other important aspects of health history? _____

_____

Review of Systems

Constitution

Activity Change	yes	no
Appetite change	yes	no
Chills	yes	no
Sweating	yes	no
Fatigue	yes	no
Fever	yes	no
Unexpected weight change	yes	no

HEENT

Congestion	yes	no
Dental Problem	yes	no
Drooling	yes	no
Ear pain	yes	no
Facial swelling	yes	no
Hearing loss	yes	no
Mouth sores	yes	no
Nosebleeds	yes	no
Postnasal drip	yes	no
Runny nose	yes	no
Sinus pain	yes	no
Sinus pressure	yes	no
Sneezing	yes	no
Sore Throat	yes	no
Ringing in ears	yes	no
Trouble swallowing	yes	no
Voice changes	yes	no

Eyes

Eye discharge	yes	no
Eye itching	yes	no
Eye pain	yes	no
Eye redness	yes	no
Sensitivity to light	yes	no
Visual changes	yes	no

Respiratory

Chest tightness	yes	no
Choking	yes	no
Cough	yes	no
Shortness of Breath	yes	no
Wheezing	yes	no

Cardiac

Chest pain	yes	no
Leg swelling	yes	no
Heart "fluttering"/ palpitations	Yes	no

GI

Bloating	yes	no
Abdominal pain	yes	no
Rectal bleeding	yes	no
Blood in stool	yes	no
Constipation	yes	no
Diarrhea	yes	no
Nausea	yes	no
Rectal Pain	yes	no
Vomiting	yes	no

Endocrine

Cold intolerance	yes	no
Heat intolerance	yes	no
Increased thirst	yes	no
Increased appetite	yes	no
Increased urination	yes	no

GU

Difficulty urination	yes	no
Painful intercourse	yes	no
Pain with urination	yes	no
Bed-wetting	yes	no
Flank pain	yes	no
Frequency of urination	yes	no
Genital sore	yes	no
Blood in urine	yes	no
Pelvic pain	yes	no
Urinary urgency	yes	no
Urine decreased	yes	no

Female Reproductive

Last pap date _____

Last mammogram date_____

History of abnormal pap	yes	no
Abnormal vaginal bleeding	yes	no
Abnormal Vaginal discharge	yes	no
Vaginal pain	yes	no
Irregular menses	yes	no
Painful menstruation	yes	no
Breast pain	yes	no
Nipple discharge	yes	no

Male Reproductive

Testicular pain	yes	no
Testicular swelling	yes	no
Penile pain	yes	no

Musc

Joint pain	yes	no
Back pain	yes	no
Difficulty walking	yes	no
Joint swelling	yes	no
Muscle pain	yes	no
Neck pain	yes	no
Neck stiffness	yes	no

Skin

Color changes	yes	no
Rash	yes	no
Wounds	yes	no
Change in skin/hair/nails	yes	no
Breast lump	yes	no

Allergies/ Immuno

Environmental allergies	yes	no
Food allergies	yes	no
Immunocompromised	yes	no

Neurological

Dizziness	yes	no
Facial drooping/asymmetry	yes	no
Headaches	yes	no
Light-headedness	yes	no
Numbness	yes	no
Seizures	yes	no
Speech difficulty	yes	no
Loss of consciousness	yes	no
Tremors	yes	no
Weakness	yes	no

Hematologic

Swollen lymph nodes	yes	no
Bruises/bleeds easily	yes	no

Psychiatric

Agitation	yes	no
Behavior problems	yes	no
Confusion	yes	no
Decreased concentration	yes	no
Depression	yes	no
Hallucinations	yes	no
Hyperactive	yes	no
Nervous/anxious	yes	no
Thoughts of/ actions of Self-Harm	Yes	no
Sleep problems	yes	no
Suicidal thoughts	yes	no