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

Cardiology

Chest pain	yes	no
Leg swelling	yes	no
Varicose Veins	yes	no
Palpitations	yes	no

Constitutional

Fatigue	yes	no
Fever	yes	no
Weight changes	yes	no

Dermatology

Change is skin/hair/nails	yes	no
Breast lump	yes	no
Rash	yes	no
Itching	yes	no

Endocrinology

Thyroid issues	yes	no
Gland or hormone issues	yes	no
Diabetes	yes	no
Heat intolerance	yes	no
Cold intolerance	yes	no
Skin changes	yes	no

Ear/Nose/Throat

Sores in mouth	yes	no
Ear pain	yes	no
Sinus problems	yes	no
Hearing loss	yes	no
Ringing in ears	yes	no
Nose bleeds	yes	no
Sore throat	yes	no
Swollen glands in neck	yes	no

Female Reproductive

Last pap date ____ normal	yes	no
Last mammogram ___ normal	yes	no
Abnormal vaginal discharge	yes	no
Irregular menses	yes	no
Painful menstruation	yes	no
Breast pain	yes	no
Nipple discharge	yes	no

Gastroenterology

Nausea	yes	no
Diarrhea	yes	no
Abdominal pain	yes	no
Painful bowel movements	yes	no
Vomiting	yes	no
Change in bowel habits	yes	no
Headaches	yes	no
Constipation	yes	no
Blood in Stool	yes	no

Hematology/Lymphatic

Unusual bleeding or bruising	yes	no
Phlebitis	yes	no
Slow to heal after cuts	yes	no
Anemia	yes	no
Blood transfusion	yes	no

Male Reproductive

Testicle pain	yes	no
Sexual difficulties	yes	no

Musculoskeletal

Muscle weakness	yes	no
Muscle pain or cramps	yes	no
Difficulty walking	yes	no
Joint pain	yes	no
Joint swelling	yes	no
Joint stiffness	yes	no

Neurology

History of head trauma	yes	no
History of stroke	yes	no
Seizures	yes	no
Tremor	yes	no
Tingling/numbness	yes	no
Dizziness	yes	no
Memory loss	yes	no

Psychology

Nervousness	yes	no
Depression	yes	no

Respiratory

Short of breath with exercise	yes	no
Short of breath lying down	yes	no
Wheezing	yes	no
Persistent Cough	yes	no
Coughing up blood	yes	no

Urology

Change in force of strain when urinating	yes	no
Urinary Frequency	yes	no
Pain with urination	yes	no
Urinary incontinence	yes	no
Blood in urine	yes	no
Kidney Stones	yes	no