MOREHOUSE HEALTHCARE

PATIENT HISTORY FORM

Name: _____ Age: _____ Date:_____

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY. IF YOU ARE UNSURE OF A QUESTION, PLEASE LEAVE IT BLANK.

What is the purpose for today's visit? _____ Follow-Up appointment for _____
_____ Routine exam/physical (Skip questions 1-5)
_____ Problem/Sick (Answer questions 1-5)

1. When did this problem start? _____
2. Where is the problem located? _____
3. How much does this bother you on a scale of 1-10?
4. Does anything else bother you? ☐ Yes ☐ No Describe _____
   _____
5. Have you been treated for this problem before? ☐ Yes ☐ No

Do you currently have any of the following? (Review of Systems)

Fevers?	☐ Yes	☐ No	Hemorrhoids?	☐ Yes	☐ No
Chest Pain?	☐ Yes	☐ No	Back Pain?	☐ Yes	☐ No
Shortness of Breath?	☐ Yes	☐ No	Headaches?	☐ Yes	☐ No
Blurred Vision?	☐ Yes	☐ No	Skin Rashes?	☐ Yes	☐ No
Depression?	☐ Yes	☐ No	Nosebleeds?	☐ Yes	☐ No
Weight Change?	☐ Yes	☐ No	Appetite Changes?	☐ Yes	☐ No
Arthritis?	☐ Yes	☐ No	Joint Pain?	☐ Yes	☐ No

List any allergies: _____

*Past medical/family/social history: (check all that apply)

Pt.	Family		Pt.	Family	
		Cancer			Heart Problems
		Emotional/Psychological Problems			High Blood Pressure
		Diabetes (high sugar)			Stroke
		Lung Disease			Allergies

*Are you taking any medicines? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

Previous surgical operations/procedures/hospitalizations/serious injuries? _____

_____

Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

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Comments/Medication List:

_____

_____

_____

Assistant Signature/Date: _____

Resident Signature/Date: _____

Physician Signature/Date: _____