

MR# _____

Infectious Disease Services of Georgia, P.C. Comprehensive Patient History

Patient Name: _____

Date of Birth _____

Date: _____

What is the reason for today's visit? _____

Describe the following:

Location: _____ How long have you had this problem? _____

How severe is this problem? mild moderate very How often are you having the problem? _____

What caused the problem? _____

Do you know of anything else that may have contributed to this problem? _____

Does anything else occur with this problem? _____

Provider Comments: I have confirmed the above information with the patient and the following are any additional comments: _____

List previous hospitalizations/Surgeries/Serious Injuries

When?

_____	_____
_____	_____
_____	_____
_____	_____

List any allergies you have.

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

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

Have you ever had the following?								
Cancer.....	yes	no	Diabetes.....	yes	no	Hypertension.....	yes	no
Arthritis/Gout.....	yes	no	Stroke.....	yes	no	Heart trouble.....	yes	no
Acute Infections.....	yes	no	Convulsions.....	yes	no	Bleeding Tendency.....	yes	no
			Venereal Disease.....	yes	no	Hereditary Defects.....	yes	no

Family Medical History

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

Have you recently experienced any of the following?

PLEASE ANSWER ALL QUESTIONS

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

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

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
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 <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		

Date

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

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
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

List any medications you are now taking.

History was filled out by other than patient. Print Name and relationship: _____

Patient Signature: _____

I have reviewed and confirmed this information with the patient. Provider Signature: _____