

Center for Advanced Medical Care

Patient History

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization.

Today's Date: ____/____/____ Date of Last Physical Exam: ____/____/____

Last Name: _____ First Name: _____ Middle: _____

Social Security No.: ____-____-____ Date of Birth: ____/____/____ Gender: M F

Chief Complaint:

What is the main reason for your visit today (describe your problem in detail).

History of Present Illness

Please answer the following questions.

Problem _____ When did it start? Date _____ Wks Mths Yrs
Is it always there? Y N What part of your body? _____
How severe is it? Mild Moderate Severe Have you ever had this problem in the past? Y N
Does anything help the problem? Y N If so what? _____
Does anything make the problem worse? Y N If so what? _____
Does the problem interfere with your normal functions? Y N
If Yes please explain: _____

Physician use only (Comments/Notes)

# Answers	Level of Service
1-3 or 4+	1 or 2, 3-5

Past Medical Family & Social History

List any personal past illness/surgeries. None List all serious illnesses in your immediate family. None
(i.e. Diabetes, Breast Cancer, heart disease)

Do you have any medication allergies? Y N To what? _____

Are you on any medication? None Drink Alcohol? Y N Drinks/wk _____

Name of Drug Dose/mg #Times Per Day Drink Caffeine? Y N Servings/wk _____

Use Seatbelts? Y N

Travel Internationally? Y N

Smoke (now or past)? Y N

Number of packs/day _____

Year you quit _____

Sunscreen? Rarely Occasionally Frequently

Physician use only (Comments/Notes)

# Answers	Level of Service
1-3 or 4+	1 or 2, 3-5