ARC Healthcare
Healthy Inside & Out

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PATIENT HISTORY FORM

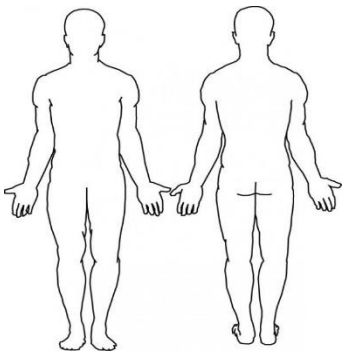
Note: this is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE:_____ _____ _____ **DATE LAST PHYSICAL EXAM:**
LAST NAME:_____**FIRST NAME:**_____**MIDDLE:**_____
DATE OF BIRTH: **AGE:**_____ **SOCIAL SECURITY NO.**_____

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

HISTORY OF PRESENT ILLNESS



Location of the Problem (e.g. Abdomen, back, legs, side)

_____

On the Scale of 1-10, with 10 being most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

_____

Does anything help or make the problem worse? (e.g. Moving around, standing up, lying on the side)

_____

How long does this problem last? (e.g. 10 minutes, 1 hour, constantly)

_____

Is there anything thing else occurring at the same time? (e.g. nausea, rash, headaches) ☐Yes ☐No
If yes, please explain: _____

Is the problem constant or variable? (e.g. Dull then sharp, very sharp then leaves, always sharp)

_____

Does this problem interfere with your normal functions? ☐Yes ☐No
If yes, please explain: _____

Please list medication/dosage	Allergies:

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Review of Systems

Do you now or have you had any problems related the following systems?

Constitutional Symptoms

☐ Fever ☐ Chills ☐ Headache ☐ Other: _____

If yes, please explain: _____

Eyes

☐ Blurred Vision ☐ Double Vision ☐ Pain ☐ Other: _____

If yes, please explain: _____

Ears/Nose/Throat/Mouth

☐ Ear infection ☐ Sore Throat ☐ Sinus problem ☐ Other: _____

If yes, please explain: _____

Respiratory

☐ Wheezing ☐ Frequent cough ☐ Shortness of Breath ☐ Other: _____

If yes, please explain: _____

Gastrointestinal

☐ Abdominal pain ☐ Indigestion ☐ Nausea/ vomiting ☐ Other: _____

If yes, please explain: _____

Genitourinary

☐ Urine retention ☐ Urinary frequency ☐ Painful urination ☐ Other: _____

If yes, please explain: _____

Musculoskeletal

☐ Joint pain ☐ Back pain ☐ Neck pain ☐ Other: _____

If yes, please explain: _____

Integumentary

☐ Skin rash ☐ Boils ☐ Persistent itching ☐ Other: _____

If yes, please explain: _____

Neurological

☐ Tremors ☐ Numbness/tingling ☐ Dizzy spells ☐ Other: _____

If yes, please explain: _____

Endocrine

☐ Excessive thirst ☐ Tired/sluggish ☐ Too hot/cold ☐ Other: _____

If yes, please explain: _____

Cardiovascular

☐ Chest pain ☐ Varicose veins ☐ High blood pressure ☐ Other: _____

If yes, please explain: _____

Hematologic/ Lymphatic

☐ Swollen glands ☐ Blood clotting problem ☐ Other: _____

Allergies/ Immunologic

☐ Hay Fever ☐ Drug allergies ☐ Other: _____

Psychologic

☐ Are you generally satisfied with your life? ☐ Do you feel severely depressed?

☐ Have you considered suicide? ☐ Other: _____

If yes, please explain: _____

Physician use only: (Comments/ Notes):

#Answer	Level of Service
0-1	1 or 2
2-9	3
10+	4 or 5

Physician: _____ **Signature:** _____ **Date:** _____/_____/_____