PATIENT HISTORY SHEET

To be completed by patient:

Name: ______________________________ Age: ________ Sex: ________ Date: __________________
Referring doctor: ____
Reason for visit: ____

Past Medical History - patient
____
____
____

Past Surgical History - Patient
____
____
____

Other Treating Physicians: ____
____
____

Significant Family Medical History:
Parents: ______________________________ Siblings: ________________________________
______________________________________ ____

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To be completed by nurse and physician

Social history: Smoke? ____________ Use Alcohol? ____________ Married? ____________
Occupation: ____

Circle those systems with problem and explain on right

Eye/ear/nose/throat: ____
Lungs: ____
Heart: ____
GU (Kidney/bladder): ____
GI (Stomach/intestines): ____
Muscles: ____
Skin: ____
Psychiatric: ____
Neurological: ____
Endocrinologic: ____
Hematologic: ____

Date: ____________________ Signature of patient: ____________________________________

Date: ____________________ Signature of doctor: ____________________________________