Proliance
Puyallup Surgeons

Patient History Form

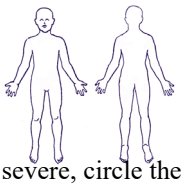
Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date _____/_____ /_____ Date of last physical exam _____/_____/_____
Last Name _____ First Name _____ Middle Initial _____
Social Security No. _____ Date of Birth _____ / _____ / _____
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

Location of the problem Front Back
Abdomen Back Leg
Other _____



On a scale of 1-10, with 10 being the most severe, circle the Number that best describes the problem?
1 2 3 4 5 6 7 8 9 10

When did you notice the problem?
2 days ago 2 weeks ago 1 month ago
Other _____

Does anything help or make the problem worse?
Moving around Standing up Lying on my side
Other

How long does the problem last?
30 minutes 1 hour It is always there
Other _____

Is anything else occurring at the same time?
Yes No If yes, please explain.
Nausea Rash Headaches
Other _____

Is the problem constant or variable?
Dull then Sharp Very sharp then leaves Always there
Other _____

Does the problem interfere with your normal functions
Yes No If yes, please explain.
Other _____

Physician use only: (Comments/Notes)

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

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.)

List any personal past illnesses and/ or Surgeries and when they occurred.
Illness/Surgery Date

Are you on any medications? Yes No (if yes, list all)

Are you on a special diet? Yes No (if yes, please explain)

Do you smoke? Y N
If yes, how much?
Do you drink? Y N
If yes, how much?

Do you have allergies? Yes No (if yes, please explain)

Physician Use Only: (Comments/Notes)

# Answer	Level of Service
0	1 or 2
1 – 2	3
3	4 or 5

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No

Constitutional Symptoms					
Fever	Y	N	Headache	Y	N
Chills	Y	N	Other		
Eyes					
Blurred Vision	Y	N	Double Vision	Y	N
Pain	Y	N	Other		
Ear/Nose/Throat/Mouth					
Ear Infection	Y	N	Sinus Problems	Y	N
Sore Throat	Y	N	Other		
Respiratory					
Wheezing	Y	N	Shortness of breath	Y	N
Frequent Cough	Y	N	Other		
Gastrointestinal					
Abdominal Pain	Y	N	Indigestion/Heartburn	Y	N
Nausea/Vomiting	Y	N	Other		
Genitourinary					
Urine Retention	Y	N	Urinary Frequency	Y	N
Painful Urination	Y	N	Other		
Musculoskeletal					
Joint Pain	Y	N	Back Pain	Y	N
Neck Pain	Y	N	Other		
Integumentary					
Skin Rash	Y	N	Boils	Y	N
Persistent Itching	Y	N	Other		
Neurological					
Tremors	Y	N	Numbness/tingling	Y	N
Dizzy Spells	Y	N	Other		
Endocrine					
Excessive Thirst	Y	N	Tired/sluggish	Y	N
Too hot/cold	Y	N	Other		
Cardiovascular					
Chest Pains	Y	N	Varicose Veins	Y	N
High Blood Pressure	Y	N	Other		
Hematologic/Lymphatic					
Swollen Glands	Y	N	Blood clotting problem	Y	N
Other					
Allergic/Immunologic					
Hay Fever	Y	N	Drug Allergies	Y	N
Other					
Psychological					
Are you generally satisfied with your life?			Y	N	
Do you feel severely depressed?			Y	N	
Have you considered suicide?			Y	N	
Other					

Please explain any Yes answers here

Physician use only: (Comments/Notes)

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

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