

Comprehensive History Form

Name: _____ Family Physician: _____

Family Physician Address: _____

Family Physician Phone: () _____ Date Last Seen: _____

Age: _____ Height: _____ Weight: _____ Shoe Size: _____

Have you been treated by a Specialist: Yes NO If yes, for what condition: _____

Review of Systems: (Check any of the following that you have, or have had in the past)

- | | | |
|---|---|---|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Sores |
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Trouble Breathing | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Cough | <input type="checkbox"/> Poor Balance |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Upset Stomach | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Sinus Congestion | <input type="checkbox"/> Bloody Stools | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Bloody Nose | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Burning with Urination | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Food Allergies |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Seasonal Allergies |

If none of the above please indicate with a check mark in the box: (None)

Past Medical History:

- | | | |
|----------------------|------------------------------|-----------------------------|
| Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Circulation Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lung Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thyroid Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other _____ | | |

Medications: (Name, Dose and How Often Taken)

(If you have a current list we will copy it)

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

Previous Surgery (s): You may use back of form if necessary

- 1 _____
- 2 _____
- 3 _____
- 4 _____

Allergies: _____

