PATIENT HISTORY FORM

SENIOR CARE MEDICAL ASSOCIATES, INC.

TODAY'S DATE _____/_____/_____ DATE OF BIRTH _____/_____/_____

LAST NAME _____ FIRST NAME _____

CHIEF COMPLAINT(What is the main reason for your visit today?):

_____

PAST MEDICAL HISTORY

List anysignificant illnesses you have had(Example: diabetes, cancer, blood pressure, heart disease, stroke, thyroid, etc.):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List any surgery you have had:

_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____

List significant diseases that your family has had(Example: diabetes, cancer, blood pressure, heart disease, stroke, thyroid, etc.):
If deceased, cause of death and age:

Mother: _____
Father: _____
Siblings: _____
Children: _____
Other Family Members: _____

SOCIAL HISTORY

Do you smoke? Yes No
If yes, how many packs a day?

How many years? _____

Have you ever smoked?
Yes No
If yes, and you quit, when?
Year _____

Do you drink alcohol on a regular basis? Yes No
If yes, how much and how often?

Do you exercise regularly?

If yes, how much?
Type: walk/run/swim/_____
Duration: > 20 min. Yes No
Frequency: > 2x per week
Yes No

Are you on a special diet?
Yes No
If yes, what type of diet?
Sodium Restricted
Diabetic
Cholesteral
Other _____

Did you ever use recreational drugs on a regular basis?
Yes No
If yes, how much and how often?

Are you currently taking any medication? If yes, please list it all.

_____
_____
_____
_____
_____
_____
_____

List any allergies you have:

_____
_____
_____
_____
_____
_____
_____

# Answer	Level 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
Weight	Y	N
Fatigue	Y	N
Do you use walking aids?	Y	N

Other: _____

Genitourinary

Urinary frequency	Y	N
Kidney Stone	Y	N
Slow Stream	Y	N
Painful urination / blood in urine	Y	N
Loss of urine (incontinence)	Y	N

Other: _____

Allergies / Immunologic

Runny nose	Y	N
Post nasal drip	Y	N
Itchy eyes	Y	N
Swollen glands	Y	N

Other: _____

Neurological

Headache	Y	N
Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N

Other: _____

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other: _____

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Change in bowel habits	Y	N
Blood in stool	Y	N
Do you wear dentures?	Y	N

Other: _____

Cardiovascular

Chest pain	Y	N
Palpitations	Y	N
Varicose veins	Y	N

Other: _____

Gynecologic (Women Only)

Abnormal vaginal bleeding?	Y	N
Painful intercourse	Y	N
Breast lump / nipple discharge	Y	N

Other: _____

Integumentary

Skin rash	Y	N
Skin cancer	Y	N
Unusual skin lesions	Y	N
Itching	Y	N

Other: _____

Musculoskeletal

Joint pain or swelling	Y	N
Neck pain	Y	N
Back pain	Y	N
History or fracture	Y	N

Other: _____

Ear/Nose/Throat/Mouth

Hearing loss	Y	N
Ear pain / Pressure	Y	N
Sore throat	Y	N
Do you wear hearing aids?	Y	N

Other: _____

Eyes

Blurred vision	Y	N
Double vision	Y	N
Eye pain	Y	N
Do you wear glasses?	Y	N

Other: _____

Respiratory

Wheezing	Y	N
Chronic cough	Y	N
Shortness of breath	Y	N

Other: _____

Psychological

Are you generally satisfied with your life?	Y	N
Do you feel severly depressed?	Y	N
Have you ever considered suicide?	Y	N
Do you feel overly anxious?	Y	N

Other: _____

Hemotologic/Lymphatic

Swollen glands	Y	N
Excessive bleeding or bruising	Y	N
Leg swelling	Y	N

Other: _____

Activities of Daily Living

Can you take care of your personal needs?	Y	N
Can you bathe yourself?	Y	N
Can you dress and feed yourself?	Y	N
Able to care for your personal and toileting needs?	Y	N

Other: _____

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

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