FILL OUT "**ALL**" INFORMATION ON THIS SHEET

Sioux Falls, SD
605-328-2663

DATE:____________________
PATIENT:____________________
MRN:____________________

Date of Birth ____/____/____ Phone number: ____________ Sex: ☐ F ☐ M Ht:______Wt:______ Hand Dominance: ☐ R ☐ L

Who Sent You To This Clinic? ____________________

HEALTH HISTORY OF THE PATIENT

	YES	NO
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Bleeding Disorders		
Lung Disease		
Arthritis		
Gout		
Seizures		
Mental Illness		
Depression		
Kidney Trouble or Stones		
Cancer		
Alcoholism		
Serious Injuries		
Tuberculosis		
Phlebitis		
Anemia		
Stomach Ulcers		
Liver Trouble		
Thyroid Trouble		
AIDS		
Other Illnesses		

Explain all YES answers or other conditions:

____

____

Chronic Conditions:

____

____

List all surgeries (include approx. dates):

____

____

Current medications and dosages:

____

____

____

____

____

____

Allergies: (None ☐)

____

____

____

FAMILY HISTORY

	YES	NO
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Gout		
Seizures		
Mental Illness		
Depression		
Kidney Trouble or Stones		
Cancer		
Bleeding Disorders		
Alcoholism		
Other		

Explain all YES answers:

____

____

Cause of death of parents/brothers/sisters:

____

____

SOCIAL HISTORY

Most recent occupation/job:

____

☐ Currently Employed
☐ Disabled
☐ Retired

☐ Married ☐ Single ☐ Divorced

Number of children living: ________

Currently living alone? ☐ YES ☐ NO

Smoke: _______packs a day
☐ Do You Use Any Tobacco Products

Alcohol:
☐ Never
☐ Occasional (<7 drinks/week)
☐ Moderate to Heavy

Illicit Drug Use:
☐ None
☐ Presently
☐ Past problem

REVIEW OF SYSTEMS

Have you recently had or do you now	YES	NO
Reading Glasses		
Change of Vision		
Loss of Hearing		
Ear Pain		
Hoarseness		
Nosebleeds		
Difficulty Swallowing		
Morning Cough		
Shortness of Breath		
Chills or Fever		
Heart or Chest Pain		
Abnormal Heartbeat		
Badly Swollen Ankles		
Calf Cramps with Walking		
Poor Appetite		
Toothache		
Gum Trouble		
Nausea or Vomiting		
Stomach Pain		
Ulcers		
Frequent Belching		
Frequent Loose Bowel Movements		
Blood in Bowel Movement		
Frequent Constipation		
Hemorrhoids		
Frequent Urination (pass water)		
Burning on Urination		
Difficulty Starting Urination		
Difficulty Stopping Urination		
Frequent Headaches		
Blackouts		
Seizures		
Frequent Rash		
Hot or Cold Spells		
Recent Weight Change		
Nervous Exhaustion		
Insomnia		
Depression		
Nervous Tension		

Female Patients Only

-Irregular Periods		
-Are You Pregnant?		

____
This form was completed by: Date

____
Physician's Signature Date

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