

# FIRST VISIT COMPREHENSIVE HISTORY

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

REASON FOR YOUR VISIT: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

REFERRING DOCTOR: \_\_\_\_\_ FAMILY DOCTOR: \_\_\_\_\_

OTHER DOCTORS THAT YOU SEE OR WOULD LIKE REPORTS SENT TO: \_\_\_\_\_  
\_\_\_\_\_

## **PAST MEDICAL HISTORY**

1. History of chronic disease (check all that apply)

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|---|--|--|
| <input type="checkbox"/> Diabetes 250               | <input type="checkbox"/> High Blood Pressure 401 | <input type="checkbox"/> Bleeding Disorder 286.9 |
| <input type="checkbox"/> Low blood sugar 251.2      | <input type="checkbox"/> Low Blood Pressure 458  | <input type="checkbox"/> Heart Attack 410        |
| <input type="checkbox"/> Peptic Ulcer 533           | <input type="checkbox"/> Kidney Disease 753.10   | <input type="checkbox"/> Stroke 437.9            |
| <input type="checkbox"/> Arthritis / Gout V13.4     | <input type="checkbox"/> Anemia 280              | <input type="checkbox"/> Transfusion Prob. V58.2 |
| <input type="checkbox"/> Asthma 493                 | <input type="checkbox"/> Thyroid Problems 246.9  | <input type="checkbox"/> Other: _____            |
| <input type="checkbox"/> Bronchitis / Emphysema 490 | <input type="checkbox"/> Epilepsy / Seizure 345  |  |
| <input type="checkbox"/> Chest pain 786.5           | <input type="checkbox"/> Cancer 229              |  |
| <input type="checkbox"/> Pacemaker V45.01           |  |  |

2. **LIST ALL OPERATIONS AND HOSPITALIZATION** – Please be complete

Operation/Hospitalization

Doctor

Date

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3. List any allergies to medications and the reaction you had (itching, rash, difficulty breathing)

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No Yes 4. Are you currently taking any medication? Please give a complete list on medication form.

## **FAMILY HISTORY**

Please list any premature deaths in your family or diseases that run in your family.

(Specifically heart attacks, high blood pressure, stroke, diabetes, kidney, or respiratory disease, bleeding disorder, cancer or arthritis)

Relationship

Disease

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## **SOCIAL HISTORY**

- No Yes 1. Do you or have you ever used tobacco? Pack per day \_\_\_\_\_ for \_\_\_\_\_ years.
- No Yes 2. Do you drink alcohol? Drinks or ounces per day \_\_\_\_\_. Drinks per week \_\_\_\_\_ or Socially
- No Yes 3. Do you use any drugs not prescribed by a physician?
- No Yes 4. Do you have risk factors for HIV / Aids such as history of intravenous drug use, homosexuality, multiple sex partners or blood transfusion?