# **KAT MOTLAGH'S HEALTH CLINIC** – PATIENT HISTORY

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________________________

Social Security No _______________ Date of Birth _____/_____/__________

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

______________________________________________________________________________

______________________________________________________________________________

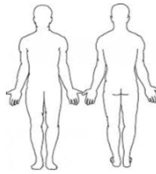
## History of Present Illness

Please answer the following questions

Location of the problem

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 first 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

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 the Sharp Very sharp then leaves Always there

Other _____________________________________

## Past Medical, Family & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.) Please indicate if living or deceased, cause of death, and age.

Mother ______________________ Grandparents __________________ List any personal past illness

Father ______________________ Other ________________________

Siblings _____________________

Surgical history Date

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

Do you have allergies? (Medication/Food, indicate reaction):

☐None or ____________________________________________

Tobacco use? ☐ Yes ☐ No
If yes, how much? ___________

Alcohol use? ☐ Yes ☐ No
If yes, how much? ___________

Do you exercise regularly? ☐ Yes ☐ No
If yes, how much? ___________

Caffeine? ☐ Yes ☐ No
If yes, how much? ___________

Current Occupation:
_____________________________

Marital Status: (Other) _______________
Married, Single, Divorced, Domestic Partner

Are you currently taking any medication? (Please list name / dose / frequency if known)

Immunizations: (Please check every box that applies, or provide copy of immunization record) ☐ Tetanus ☐ Pneumonia ☐ Influenza ☐ Zoste (shingles) ☐ HPV Have you been tested or vaccinated for Hepatitis A, B, C? _________________

Last TB screening: __________ Positive ☐ Negative ☐ Chest X-Ray Done? (If Positive) _________________