Stony Point Family Medicine, PA ● 35 Ruritan Park Road, Stony Point, NC 28678 ● 704-585-9373

PATIENT HISTORY FORM

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:_____/_____/_____ (Please, print clearly)

Name: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip:_____

Phone number: _____ Social Security number: _____

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? (Circle one, or explain):

Follow up appointment Blood work Other :_____
Physical DOT _____

HISTORY OF PRESENT ILLNESS

Location of the problem:
Head Back Abdomen Legs Arms
Other_____
_____

On a scale from 1-10, with 10 being the most severe, circle the number that best describes your problem:
1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?
2 hours ago 2 weeks ago 1 month ago

Does anything help or make the problem worse?
Moving around Standing up Lying on side

How long does the problem last? 30 mins 1 hour Constant
Other:_____

Is anything else occurring at the same time?
YES NO If yes, please circle or explain:
Nausea Rash Headaches Other:_____
_____

Is the problem constant or variable? Constant
Dull, then sharp Very sharp, then leaves

Does the problem interfere with your normal functions?
YES NO If yes, explain:_____
_____

PAST MEDICAL & SOCIAL HISTORY

If there are no changes since last visit, check here: [ ]

List all MEDICATIONS/SUPPLEMENTS:	List all ALLERGIES:	List all SERIOUS ILLNESSES in your immediate family:
	Do you Use:	List MEDICAL PROBLEMS:
	Tobacco? Yes No	
	Alcohol? Yes No	List SURGERIES:
	Illegal Drugs? Yes No	

REVIEW OF SYMPTOMS

Do you now have or have you had any problems related to the following systems? Circle Yes or No
(Please explain any YES answers in the space provided.)

Constitutional Symptoms
Fevers Y N
Chills Y N
Headache Y N
Sleep difficulty Y N
Other: _____

Eyes:
Blurred vision Y N
Double vision Y N
Pain Y N
Other: _____

Allergic/Immunologic:
Hay fever Y N
Drug allergies Y N
Other:_____

Respiratory:
Wheezing Y N
Frequent cough Y N
Shortness of breath Y N
Other:_____

Cardiovascular:
Chest pain Y N
Varicose veins Y N
High Blood Pressure Y N
Other: _____

Genitourinary:
Urine retention Y N
Painful urination Y N
Urinary frequency Y N
Other:_____

Gastrointestinal:
Abdominal pain Y N
Nausea/Vomiting Y N
Indigestion/Heartburn Y N
Other:_____

Musculoskeletal:
Joint pain Y N
Neck pain Y N
Back pain Y N
Other:_____

Hematologic/Lymphatic:
Swollen glands Y N
Blood clotting problem Y N
Other: _____

Skin:
Skin rash Y N
Boils Y N
Persistent itch Y N
Other: _____

Neurological/Psychological:
Tremors Y N
Dizzy spells Y N
Numbness/tingling Y N
Are you satisfied with your life? Y N
Do you feel depressed? Y N
Have you considered suicide? Y N
Other:_____