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.

Patient name:_____ **Date:**_____

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

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History of Present Illness

Please answer the following questions

When did you first notice the problem? Explain:	**How long does the problem last?** 30 minutes 1 hour It is always there Comes and goes Other:
Location of the problem: Abdomen Back Leg Other:	**Is anything occurring at the same time?** **Yes** **No** If yes, explain:
Is the problem constant or variable? Sharp or Dull? Explain:	**Does anything make the problem worse?** Explain:
On a scale of 1 to 10, with 10 being the most severe, circle the number that best describes the severity of your problem. 1 2 3 4 5 6 7 8 9 10	**Does the problem interfere with your normal daily functions?** **Yes** **No** If yes, explain:

Physician use only: (Comments / Notes)

Urinalysis
Leuk-
Nitrites-
Urobili-
Protein-
pH-
Blood-
SG-
Ket-
Bili-
Gluc-

Micro
WBC-
RBC-
Bact-
Crystal-
Phos-
Epi's
Mucous-

# Answers	Level of Service	Initial	Date
1-3	1 or 2		
4+	3 - 5		