

# Current History Form

COG #

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. It is very important that you clearly tell us your current or past history as this assists the physicians in understanding your problem and executing the best care and outcome for your current condition.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex  Male  Female

Age: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Your Occupation? \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Primary Care Doctor \_\_\_\_\_

## Please darken the circles like this...

Your Chief Complaint: \_\_\_\_\_

|                                     |                       |                       |                       |                       |                       |                       |                       |                       |
|-------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| How long have you had this problem? | 1-2                   | 3-5                   | 6-8                   | 9-12                  | days                  | weeks                 | months                | years                 |
|                                     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|                                     | choose one            |                       |                       |                       | choose one            |                       |                       |                       |

## HISTORY OF THE PRESENT CONDITION

Date of this onset? \_\_\_\_\_ Ever had this before?  Yes  No Date? \_\_\_\_\_

Was this an injury (accident)?  Yes  No

Is your injury work / job related?  Yes  No Last date you worked? \_\_\_\_\_

Are you left or right handed?  Left  Right

State in your own words how the present problem happened and what you felt at the time:

|  |
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# Family Medical History

COG #

Fill in circles if any of the following exist in your family or relatives. Fill in circles like this

- |                                    |                                                   |                                      |                                         |
|------------------------------------|---------------------------------------------------|--------------------------------------|-----------------------------------------|
| <input type="radio"/> Arthritis    | <input type="radio"/> Peripheral Vascular Disease | <input type="radio"/> Stroke         | <input type="radio"/> Cancer            |
| <input type="radio"/> Osteoporosis | <input type="radio"/> Psychiatric Problems        | <input type="radio"/> Kidney Failure | <input type="radio"/> Seizures          |
| <input type="radio"/> Diabetes     | <input type="radio"/> Neurological problems       | <input type="radio"/> Heart Failure  | <input type="radio"/> Bleeding Problems |

Do you have a living will indicating your advanced directive?  Yes  No

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## Social History

- Marital Status:**  Single  Married  Divorced  Widowed
- Education:**  Some High school  High School Grad  College  Post Grad
- Employment:**  Currently working  Unemployed  Disabled  Retired  Other
- Exercise:**  Sedentary  Mild  Moderate  Vigorous
- Tobacco:**  Never used  Former smoker  I smoke  I chew
- Alcohol:**  Never drank alcohol  Less than 2 drinks/day  More than 2 drinks/day
- Pregnant:**  Yes  No  Planning  Unable to Conceive
- My health is:**  Excellent  Very Good  Good  Fair  Poor
- 

## Review of Systems

fill in circle if you have had any of the following in the last 2 weeks

- |                                    |                                             |                                          |                                             |
|------------------------------------|---------------------------------------------|------------------------------------------|---------------------------------------------|
| <b>General</b>                     | <b>Respiratory</b>                          | <b>Genitourinary</b>                     | <b>Psychiatric</b>                          |
| <input type="radio"/> Fever        | <input type="radio"/> Shortness of breath   | <input type="radio"/> Painful Urination  | <input type="radio"/> Depression            |
| <input type="radio"/> Chills       | <input type="radio"/> Wheezing              | <input type="radio"/> Frequent Urination | <input type="radio"/> Anxiety               |
| <input type="radio"/> Fatigue      | <input type="radio"/> Cough                 | <b>Skin</b>                              | <b>Hematologic</b>                          |
| <b>Cardiovascular</b>              | <b>Gastrointestinal</b>                     | <input type="radio"/> Poor Healing       | <input type="radio"/> Easy Bleeding         |
| <input type="radio"/> Chest Pains  | <input type="radio"/> Heartburn             | <input type="radio"/> Rash               | <input type="radio"/> Easy Bruising         |
| <input type="radio"/> Palpitations | <input type="radio"/> Nausea/Vomiting       | <b>Neurologic</b>                        | <b>Endocrine</b>                            |
| <input type="radio"/> Heart Murmur | <input type="radio"/> Blood in Stools       | <input type="radio"/> Numbness           | <input type="radio"/> Excessive Thirst      |
| <b>ENT</b>                         | <input type="radio"/> Black or Tarry Stools | <input type="radio"/> Unsteady Gait      | <input type="radio"/> Heat/Cold Intolerance |
| <input type="radio"/> Headache     |                                             | <input type="radio"/> Dizziness          |                                             |