

## History Form

Name \_\_\_\_\_, Age \_\_\_\_\_, Male  Female   
Single  Married  Divorced  Widow  Lives in \_\_\_\_\_  
Works as \_\_\_\_\_, Pt was admitted via \_\_\_\_\_ on \_\_\_\_\_ day  
time \_\_\_\_\_. History was taken by me \_\_\_\_\_, a 4<sup>th</sup> year med student on \_\_\_\_\_ day  
time \_\_\_\_\_.

**Chief Complaint:** (use pt's own words + Clarify, Precise and concise).

- 1) \_\_\_\_\_ for duration \_\_\_\_\_
- 2) \_\_\_\_\_ for duration \_\_\_\_\_
- 3) \_\_\_\_\_ for duration \_\_\_\_\_

### HPI:

Site \_\_\_\_\_, Localized  / Generalized

Onset: gradual  / sudden , while doing \_\_\_\_\_  
if gradual, rate of development \_\_\_\_\_

Character \_\_\_\_\_

Radiation \_\_\_\_\_

**Constitutional** symptoms: fever , chills , rigors , weight loss , Fatigue ,  
night sweating , \_\_\_\_\_

Timing: duration of \_\_\_\_\_ since onset, pattern is episodic  / continuous

if episodic: duration of attack \_\_\_\_\_, Frequency (every how many) \_\_\_\_\_

course: progressive  (changes in severity) \_\_\_\_\_

specific diurnal variations \_\_\_\_\_

Exacerbated by \_\_\_\_\_

and relieved by \_\_\_\_\_

Severity (0-10) \_\_\_\_\_

Hx of similar complaint \_\_\_\_\_

Ask about risk factors, Pertinent positives and negatives, All the relevant system's symptoms,  
and relevant past medical and social history \_\_\_\_\_

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**ROS:**

**General:**

- Well-being: \_\_\_\_\_,  Sleep: \_\_\_\_\_
- Appetite: \_\_\_\_\_,  Mood: \_\_\_\_\_
- Energy: \_\_\_\_\_,  Wt change \_\_KG to \_\_KG within \_\_\_\_\_

**CVS**

- Chest pain \_\_\_\_\_,  Palpitations: rate \_\_\_\_\_ rhythm \_\_\_\_\_
- Breathlessness: \_\_\_\_\_ gradual/sudden, precipitating factors \_\_\_\_\_  
Orthopnea, relieved by \_\_\_\_ pillows frequency \_\_\_\_\_, duration \_\_\_\_\_, Syncope \_\_\_\_\_  
PND around time \_\_\_\_\_ exercise effect worsen/ better / no change  
on minimal effort like \_\_\_\_\_  Pain on walking (claudication) yes/no  
distance \_\_\_\_\_, relieved on rest? \_\_\_\_\_  
NYHA CLASS \_\_\_\_\_ unilateral/bilateral, location \_\_\_\_\_  
CANADIAN CLASS \_\_\_\_\_ Ankle swelling \_\_\_\_\_

**RS (always ask about duration + frequency + consistency + onset + progression)**

- Shortness of breath  Cough (Dry, productive), Sound \_\_\_\_\_
- Sputum (serous/mucous/purulent/rusty), timing (day/night), associated symp. \_\_\_\_\_  
amount \_\_\_\_\_, smell+color+taste \_\_\_\_\_ exac/relieving \_\_\_\_\_
- blood \_\_\_\_\_, masses \_\_\_\_\_  Hemoptysis \_\_\_\_\_
- Wheezes (on insp/expir), (persistence/not)  Chest pain when inspi/coughing?  Hoarseness  
(at night/on wakening)  Stidor (inspi/expir)

**GI**

- Oral ulcers (painful/painless) (recurrent/not)  Carries/other procedures \_\_\_\_\_
- Dysphagia (solids/liquids/both) which level \_\_\_\_\_
- odynophagia (pain swallowing)  Nausea  Vomiting, color+amount \_\_\_\_\_
- Indigestion  Heartburn blood \_\_\_\_\_, content \_\_\_\_\_ projectile?
- Abd. Pain

Site _____, Localized <input type="checkbox"/> / Generalized <input type="checkbox"/> Onset: gradual <input type="checkbox"/> /sudden <input type="checkbox"/> , while doing _____ if gradual, rate of development _____
Character _____ Radiation _____
Associated symptoms: nausea <input type="checkbox"/> , vomit <input type="checkbox"/> , fever <input type="checkbox"/> , chills <input type="checkbox"/> , rigors <input type="checkbox"/> , weight loss <input type="checkbox"/> , headache <input type="checkbox"/> , sweating <input type="checkbox"/> , cough <input type="checkbox"/> , _____
Timing: duration of _____ since onset, pattern is episodic <input type="checkbox"/> / continuous <input type="checkbox"/> if episodic: duration of attack _____, Frequency (every how many) _____ course: progressive <input type="checkbox"/> (changes in severity) _____
specific diurnal variations _____
Exacerbated by _____ and relieved by _____
Severity (0-10) _____

- Change in bowel movements \_\_\_\_\_ normal habit was \_\_\_\_\_ times daily, changed to \_\_\_\_\_  
 Change of color of stool to \_\_\_\_\_, Consistency of stool \_\_\_\_\_  
 Diarrhea  Constipation  Blood in stool  \_\_\_\_\_

### URO

Irritative symptoms:  Frequency  Nocturia  Urgency

Obstructive symptoms:  Retention  Hesitancy/Straining  Poor stream  Terminal Dribbling  Feeling of incomplete voiding

Abnormal Voiding:  Dysuria  Hematuria (Initial/Terminal/Total)

Volume:  Polyuria  Oliguria

Competence:  Incontinence (Stress/Urge/Overflow)

### Genital-Men

Urethral discharge  Erectile difficulties

### Genital-Women

Last menstrual period \_\_\_\_\_, timing and regularity \_\_\_\_\_

Abnormal bleeding \_\_\_\_\_,  Vaginal discharge \_\_\_\_\_

Contraception \_\_\_\_\_

Pain during intercourse \_\_\_\_\_

### Endocrine

Heat or cold intolerance  Excess thirst (polydipsia)  Change in sweating

### Musculoskeletal

joint pain  stiffness  swelling of joints  limited range of motion in particular joint \_\_\_\_\_

Falls, Why \_\_\_\_\_, associated with \_\_\_\_\_, trauma? \_\_\_\_\_

### Nervous

Headache, when \_\_\_\_\_ why \_\_\_\_\_ associated with \_\_\_\_\_

Dizziness, vertigo? \_\_\_\_\_ Light-headedness? \_\_\_\_\_, \_\_\_\_\_

fainting \_\_\_\_\_,  Fits \_\_\_\_\_

altered sensations (tingling, burning, pins)  Weakness \_\_\_\_\_

Visual disturbances \_\_\_\_\_,  hearing problems \_\_\_\_\_

Memory and concentration \_\_\_\_\_

### Other

Bleeding \_\_\_\_\_

Skin Rash \_\_\_\_\_



Allergies and symptoms \_\_\_\_\_

Remedies/Herbs \_\_\_\_\_

OTC \_\_\_\_\_

Compliance to each \_\_\_\_\_

### Family Hx

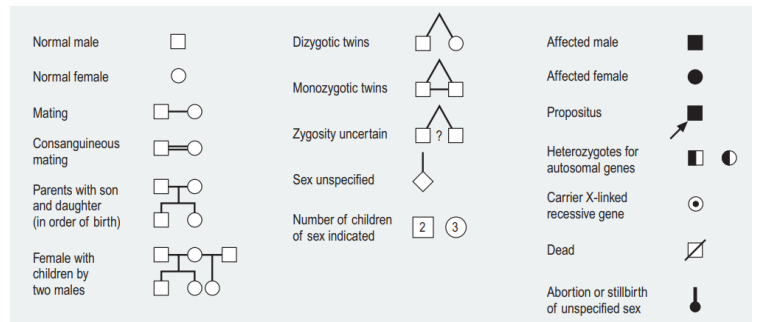
Dad living/Died of \_\_\_\_\_ at age of \_\_\_\_\_

Mom living/Died of \_\_\_\_\_ at age of \_\_\_\_\_

Documented illnesses \_\_\_\_\_

Similar complains \_\_\_\_\_

Pedigree:



**Social Hx**

Exercise \_\_\_\_\_, diet \_\_\_\_\_, homing \_\_\_\_\_

Pets \_\_\_\_\_

Travel \_\_\_\_\_

Sexual Hx \_\_\_\_\_

Smoking

Smoker, \_\_\_\_\_ packs/day, for \_\_\_\_\_ years

Ex-smoker, quit for/since \_\_\_\_\_

Quite smoking since \_\_\_\_\_

Passive smoker

**Alcohol**

**CAGE:** Cut down (1), Annoyed (1), Guilty (1), Eye opener (1)

Regular drinker

at occasions

how much?

Vaccination \_\_\_\_\_

Drug Abuse \_\_\_\_\_

Insurance \_\_\_\_\_

Who helps at home? \_\_\_\_\_