

PATIENT HISTORY FORM

3rd Department of Medicine, Medical faculty, Comenius University

Date: ____/____/____

NAME: _____
Last First

Birthdate: ____/____/____

Age: _____ Sex: F M

CURRENT COMPLAINTS: Describe briefly your present symptom:

Please list the names of practitioner / all physicians you have seen for this problem:

CURRENT MEDICATIONS

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug Dose (include strength & number of pills per day) How long have you been taking this?

1.

2.

Epidemiologic history:

Did you have any contact with COVID-19 positive person? Did you have a vaccination against Covid? How many? Do you have any travel history in the last month? If yes, which countries did you attend? Did you have a Covid? Do you have any pets (cat, dog...)? Any infectious diseases in the past?

PAST MEDICAL HISTORY (PERSONAL HISTORY) + YEAR OF DG STATEMENT

Do you now or have you ever had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Kidney stones | |

Other medical conditions (please list): any surgery? Any trauma? When?

ALLERGIC HISTORY : Do you have allergy on any drug / food/ herb ?

How did look manifestation of allergy? How did it resolve?

SOCIAL HISTORY

What is your highest education? High school Some college College graduate Advanced degree

Marital status: Never married Married Divorced Separated Widowed Partnered/significant other

What is your current or past occupation?

Are you currently working? : Yes No Hours/we ek If not, are you retired disabled sick leave?

Do you receive disability? Yes No If yes, for what disability & how long? _____

Have you ever had legal problems? (specify)

Religion:

FAMILY HISTORY Father /mother / siblings/ children : LIVING or death

CHD, HYPERTENSION, MYOCARDIAL INFARCTION, STROKE, CANCER, DM, DLP, ANY GENETIC DIS. AGE, HEALTH, AGE AT DEATH, CAUSE

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL

- Recent weight gain; how much _____
- Recent weight loss: how much _____
- Fatigue
- Weakness
- Fever
- Night sweats

MUSCLE/JOINTS/BONES

- Numbness
- Joint pain
- Muscle weakness
- Joint swelling

Where?

EARS

- Ringing in ears
- Loss of hearing

EYES

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness

THROAT

- Frequent sore throats
- Hoarseness
- Difficulty in swallowing
- Pain in jaw

HEART AND LUNGS

- Chest pain
- Palpitations
- Shortness of breath
- Fainting
- Swollen legs or feet
- Cough

NERVOUS SYSTEM

- Headaches
- Dizziness
- Fainting or loss of consciousness
- Numbness or tingling
- Memory loss

STOMACH AND INTESTINES

- Nausea
- Heartburn
- Stomach pain
- Vomiting
- Yellow jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools

SKIN

- Redness
- Rash
- Nodules/bumps
- Hair loss
- Color changes of hands or feet

BLOOD

- Anemia
- Clots

KIDNEY/URINE/BLADDER

- Frequent or painful urination
- Blood in urine

Women Only:

- Abnormal Pap smear
- Irregular periods
- Bleeding between periods
- PMS

PSYCHIATRIC

- Depression
- Excessive worries
- Difficulty falling asleep
- Difficulty staying asleep
- Difficulties with sexual arousal
- Poor appetite
- Food cravings
- Frequent crying
- Sensitivity
- Thoughts of suicide / attempts
- Stress
- Irritability
- Poor concentration
- Racing thoughts
- Hallucinations
- Rapid speech
- Guilty thoughts
- Paranoia
- Mood swings
- Anxiety
- Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:

Pregnancies:

Miscarriages:

Abortions:

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N

ABUSES: SUBSTANCE USE

DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes <input type="checkbox"/> No <input type="checkbox"/>
CANNABIS: Marijuana, hashish, hash oil					Yes <input type="checkbox"/> No <input type="checkbox"/>
STIMULANTS: Cocaine, crack					Yes <input type="checkbox"/> No <input type="checkbox"/>
STIMULANTS: Methamphetamine—speed, ice, crank					Yes <input type="checkbox"/> No <input type="checkbox"/>
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes <input type="checkbox"/> No <input type="checkbox"/>
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes <input type="checkbox"/> No <input type="checkbox"/>
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes <input type="checkbox"/> No <input type="checkbox"/>
HEROIN					Yes <input type="checkbox"/> No <input type="checkbox"/>
STREET OR ILLICIT METHADONE					Yes <input type="checkbox"/> No <input type="checkbox"/>
OTHER OPIOIDS: Tylenol, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes <input type="checkbox"/> No <input type="checkbox"/>
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, mushrooms, ecstasy, nitrous oxide					Yes <input type="checkbox"/> No <input type="checkbox"/>
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes <input type="checkbox"/> No <input type="checkbox"/>
OTHER: specify) _____					Yes <input type="checkbox"/> No <input type="checkbox"/>

SMOKING: How long do you smoke?
How much cigarettes daily?

ALCOHOL drinking: (AUDIT C questionnaire)

	0	1	2	3	4
1. How often do you have a drink containing alcohol?	never	monthly or less	2-4 times a month	2-3 times a week	4 or more
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10 or more
3. How often do you have 6 or more drinks on 1 occasion?	never	less than monthly	monthly	weekly	daily or almost daily

Name of physician: