FIRST VISIT COMPREHENSIVE HISTORY

Name: ______________________________________ Age: _________ Date: _______________

REASON FOR YOUR VISIT: ____

REFERRING DOCTOR: _________________________ **FAMILY DOCTOR**: ______________________

HISTORY OF PRESENT ILLNESS: (Please specify location, quality, duration, severity, timing/how often, context, any modifying factors and associated symptoms):

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PAST MEDICAL HISTORY

1. History of chronic disease (check all that apply)

___ Diabetes 250	___ High Blood Pressure 401.9	___ Bleeding Disorder 286.9
___ Low blood sugar 251.1	___ Low Blood Pressure 458.9	___ Heart Attack 412
___ Peptic Ulcer 533	___ Kidney Disease 753.10	___ Stroke 437.9
___ Arthritis V13.4	___ Anemia 280.9	___ Transfusion Prob. V58.2
___ Gout 274	___ Pacemaker V45.01	___ Chest pain 786.50
___ Asthma 493.90	___ Thyroid Problems 246.9	___ End Stage Renal Disease 585
___ Bronchitis 490	___ Epilepsy / Seizure 345.0	___ Other: _____________
___ Emphysema 492.8	___ Cancer 229.0	

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2. **LIST ALL SURGICAL OPERATIONS** – Please be complete

Operation/Hospitalization	*Doctor*	*Date*

FAMILY HISTORY

Please list any premature deaths in your family or diseases that run in your family.

(Specifically heart attacks, high blood pressure, stroke, diabetes, kidney, or respiratory disease, bleeding disorder, cancer or arthritis)

Relationship	Disease

SOCIAL HISTORY

No Yes 1. Do you or have you ever used tobacco?

_____ Current Smoker _____ Former Smoker _____ Never Smoked