Patient Name:_____ Date: / /

Personal Health Inventory

Main reason for today's visit

_____

(Why are you here?)

Describe your condition/concern

Location:_____

(Where is the pain/problem?)

Severity:_____

(Rate your pain/problem from 1-5. 5 being the most severe)

Timing:_____

(Does this pain/problem occur at a specific time?)

Associated signs/symptoms:

_____

(Are you having any other associated problems?)

Quality:_____

(normal vs abnormal color, activity, etc)

Duration:_____

(How long have you had it/when did it start?)

Context:_____

(Where were you when the problem started?)

Modifying factors:_____

(What makes it worse or better? Has it happened in the past?)

Medical History

Allergies

History of adverse reaction to:

Penicillin or other antibiotics	Y☐N☐
Morphine, Demerol, or other narcotics	Y☐N☐
Novocain or other anaesthetics	Y☐N☐
Aspirin or other pain remedies	Y☐N☐
Tetanus antitoxin or other serums	Y☐N☐
Iodine, methiolate or other antiseptic	Y☐N☐
Other drugs/medications	Y☐N☐

Previous Hospitalizations/Surgeries/ Serious Injuries/Trauma (Include dates)

_____

_____

_____

_____

Medications

_____

_____

_____

_____

Patient History

Use of alcohol: ☐Never ☐Rarely ☐Moderate ☐Daily

Use of tobacco: ☐Never ☐Previously but quit _____ Current packs per day _____

Use of drugs: ☐Never ☐Type/Frequency _____

Excessive exposure at home or at work to: ☐Fumes ☐Dust ☐Solvents ☐Air-borne Particles ☐Noise

Family Medical History

	Age	Diseases	If deceased, cause of death
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____
	____	_____	_____
Spouse	____	_____	_____
Children	____	_____	_____
	____	_____	_____

Patient signature:_____

(Or responsible party)

Reviewed by: _____

Date: / /