DuPage Medical Group

WE CARE FOR YOU

Patient History – Adult

Primary Care Provider:_____ **Referred By**:_____

What medical concerns would you like addressed during today's visit (chief complaint)?

_____

Please list **your** current and past **medical problems** and any prior **surgeries**:

_____

_____

Please list your current medications including dosages (if known). Please indicate any supplements, herbs, vitamins, etc.

_____ _____

_____ _____

_____ _____

_____ _____

Medication Allergies: _____

Social and Environmental Histories:

Please help us get to know you and your home environment a little better.

Personal History	Home Environment
Marital Status:_____ Children: number/ages:_____ _____ Occupation(s):_____ _____ Alcohol Use: __**Yes** __ **No** Tobacco/Smoking History: 1. Previous use: __**Yes** __**No** Quit date:_____ 2. Current use: __**Yes** __**No** If "yes," are you interested in quitting: __**Yes** __**No** 3. Packs per day/year:_____ Hobbies/Interests: _____ _____ _____	Live in: apt, house, etc.:_____ Indoor Animals: __**Yes** __ **No** List:_____ _____ Indoor Smokers: __**Yes** __ **No** List:_____ History of indoor water damage and/or indoor mold: __**Yes** __ **No** **If yes, explain**:_____ _____ Does *you* use "dust mite covers" for bedding: __**Yes** __**No** Heating and cooling (central or window AC, gas or electric heat, fireplace, etc.):_____ _____ Flooring (carpet, laminate, tile, wood, etc.): _____ _____ _____

Continue on back.

Family Medical History:

Do Immediate family members have any of the conditions listed below (do not include yourself)?

Condition	Family History	Who (i.e. mother, father, siblings, children, etc.)
Allergies	__ Yes __ No	
Sinus Problems	__ Yes __ No	
Asthma	__ Yes __ No	
Other Lung Disease	__ Yes __ No	
Eczema	__ Yes __ No	
Thyroid Problems	__ Yes __ No	
Autoimmune Disease	__ Yes __ No	
Immune Deficiency	__ Yes __ No	
Migraines	__ Yes __ No	
Other	__ Yes __ No	

Review of Systems:

Please check **Yes** or **No** to indicate if you currently have any problems in one or more of the following areas. If yes, please **circle** and briefly explain the problem.

Organ System	Yes or No	If yes, please circle all that apply
General Health	__ Yes __ No	Recurrent fever, chills, sweats, unexplained weight loss, weight gain, excessive fatigue, sleep problems
Eyes	__ Yes __ No	Blurred vision, eye pain, eye discharge, redness, watering, matting/crusting, itching, gritty sensation, eyelid rash/swelling
Ears/Nose/Throat	__ Yes __ No	Hearing loss, earache, nasal congestion, nose bleeds, abnormal taste/smell, nasal drip, post nasal drip, allergies, dry mouth, sores in mouth, sore throat, hoarseness, throat clearing
Cardiovascular	__ Yes __ No	Irregular heartbeats, hypertension, heart problems, stroke
Respiratory	__ Yes __ No	Asthma, emphysema, chronic bronchitis, cough, wheezing, shortness of breath, exercise difficulties
Gastrointestinal	__ Yes __ No	Reflux/heartburn, difficulty swallowing, nausea, vomiting, diarrhea, constipation, ulcers
Genitourinary	__ Yes __ No	Painful urination, frequent urination, incontinence due to coughing
Musculoskeletal	__ Yes __ No	Arthritis, joint pain, muscle pain, cramps, joint stiffness, joint swelling
Skin	__ Yes __ No	Dryness, rashes, itching, redness, swelling, change in moles
Neurology	__ Yes __ No	Headache, numbness/tingling, weakness, dizziness, lightheadedness
Psychiatry	__ Yes __ No	Anxiety, depression
Endocrine	__ Yes __ No	Excessive thirst, cold intolerance, diabetes
Hematology	__ Yes __ No	Anemia, bleeding problems, enlarged lymph nodes

Physician Notes:

_____

_____

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_____

☐ I have reviewed the information above. _____

Physician Signature Date