

**Comprehensive Patient History Form  
STELLA MARIS INTERNAL MEDICINE  
Hani Charles Soudah, M.D., Ph.D.**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Describe your main problem \_\_\_\_\_

Where is your problem located? \_\_\_\_\_

How severe is your problem? \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

When does this problem occur? \_\_\_\_\_

Where were you when this problem started? \_\_\_\_\_

What other things happen with this problem? \_\_\_\_\_

\_\_\_\_\_

Have you ever had the following?		
Diabetes.....	yes	no
Hypertension.....	yes	no
Cancer.....	yes	no
Stroke.....	yes	no
Heart trouble.....	yes	no
Arthritis/gout.....	yes	no
Convulsions.....	yes	no
Bleeding tendency.....	yes	no
Acute infections.....	yes	no
Venereal disease.....	yes	no
Hereditary defects.....	yes	no

List previous hospitalizations/Surgeries/Serious Injuries	When?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List Medications you are currently taking
1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____

**Patient Social History**

Marital Status:     Single     Married     Separated     Divorced     Widowed

Use of alcohol:     Never     Rarely     Moderate     Daily \_\_\_\_\_

Use of tobacco:     Never     Previously but quit     Current packs per day \_\_\_\_\_

Use of Drugs:     Never     Type/Frequency \_\_\_\_\_

**Family Medical History**

	<u>Age</u>	<u>Diseases</u>	<u>If Deceased, Cause of Death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

**PLEASE ANSWER ALL QUESTIONS**

**Have you had any of the following during the past three months?**

**CONSTITUTIONAL**

Good general health lately..... No Yes  
 Recent weight change..... No Yes  
 Fever..... No Yes  
 Fatigue..... No Yes  
 Headaches..... No Yes

**EYES**

Eye disease or injury..... No Yes  
 Wear glasses/contact lens..... No Yes  
 Blurred or double vision..... No Yes  
 Glaucoma..... No Yes

**ENT**

Hearing loss..... No Yes  
 Ringing in the ears..... No Yes  
 Earaches or drainage..... No Yes  
 Sinus problems..... No Yes  
 Nose bleeds..... No Yes  
 Mouth sores..... No Yes  
 Bleeding gums..... No Yes  
 Bad breath or bad taste..... No Yes  
 Sore throat or voice change..... No Yes  
 Swollen glands in neck..... No Yes

**CARDIOVASCULAR**

Heart trouble..... No Yes  
 Chest pains..... No Yes  
 Sudden heart beat changes..... No Yes  
 Swelling of feet, ankles or hands..... No Yes

**RESPIRATORY**

Frequent coughing..... No Yes  
 Spitting up blood..... No Yes  
 Shortness of breath..... No Yes  
 Asthma or wheezing..... No Yes

**GASTROINTESTINAL**

Loss of appetite..... No Yes  
 Change in bowel movements..... No Yes  
 Nausea or vomiting..... No Yes  
 Frequent diarrhea..... No Yes  
 Painful bowel movements or constipation..... No Yes  
 Blood in stool..... No Yes  
 Stomach pain..... No Yes

**GENTOURINARY**

Frequent urination..... No Yes  
 Burning or painful urination..... No Yes  
 Blood in urine..... No Yes  
 Change of force of strain when urinating..... No Yes  
 Incontinence or dribbling..... No Yes  
 Kidney stones..... No Yes  
 Sexual difficulty..... No Yes  
 Male – testicle pain..... No Yes  
 Female – pain with periods..... No Yes  
 Female – irregular periods..... No Yes  
 Female – vaginal discharge..... No Yes  
 Female – # pregnancies \_\_\_\_\_ # miscarriages \_\_\_\_\_  
 Female – date of last pap smear \_\_\_\_\_  
 Female – findings of last pap smear  Normal  Abnormal

**MUSCULOSKELETAL**

Joint pain..... No Yes  
 Joint stiffness or swelling..... No Yes  
 Weakness of muscles or joints..... No Yes  
 Muscle pain or cramps..... No Yes  
 Back pain..... No Yes  
 Cold extremities..... No Yes  
 Difficulty in walking..... No Yes

**SKIN**

Rash or itching..... No Yes  
 Change in skin color..... No Yes  
 Change in hair or nails..... No Yes  
 Varicose veins..... No Yes  
 Breast pain..... No Yes  
 Breast lump..... No Yes  
 Breast discharge..... No Yes

**NEUROLOGICAL**

Frequent or recurring headaches..... No Yes  
 Light headed or dizzy..... No Yes  
 Convulsions or seizures..... No Yes  
 Numbness or tingling sensations..... No Yes  
 Tremors..... No Yes  
 Paralysis..... No Yes  
 Stroke..... No Yes  
 Head injury..... No Yes

**PSYCHIATRIC**

Memory loss or confusion..... No Yes  
 Nervousness..... No Yes  
 Depression..... No Yes  
 Sleep problems..... No Yes

**ENDOCRINE**

Grandular or hormone problem..... No Yes  
 Thyroid disease..... No Yes  
 Diabetes..... No Yes  
 Excessive thirst or urination..... No Yes  
 Heat or cold intolerance..... No Yes  
 Dry skin..... No Yes  
 Change in hat or glove size..... No Yes

**HEMATOLOGIC/LYMPHATIC**

Slow to heal after cuts..... No Yes  
 Easily bruise or bleed..... No Yes  
 Anemia..... No Yes  
 Phlebitis..... No Yes  
 Past transfusion..... No Yes  
 Enlarged glands..... No Yes

**ALLERGIC/IMMUNOLOGIC**

History of skin reaction or other adverse reactions to:  
     Penicillin or other antibiotics..... No Yes  
     Morphine, Demerol or other narcotics.. No Yes  
     Novocaine or other anesthetics..... No Yes  
     Aspirin or other pain remedies..... No Yes  
     Tetanus antitoxin or other serums..... No Yes  
     Iodine, methiolate or other antiseptic... No Yes  
 Other drugs/medications \_\_\_\_\_  
 Known food allergies \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Physician Signature: \_\_\_\_\_