INFECTIOUS DISEASE SERVICES OF GEORGIA, P.C.
ROSWELL ● CUMMING ● JOHNS CREEK

COMPREHENSIVE PATIENT HISTORY

Patient Name: _____ Date of Birth: _____ Date _____

What is the reason for today's visit? _____

Describe the Following:

Location: _____ How long have you had this problem? _____

How severe is this problem? ☐ mild ☐ moderate ☐ very How often are you having the problem? _____

What caused the problem? _____

Do you know of anything else that may have contributed to this problem? _____

Does anything else occur with this problem? _____

Provider Comments: ☐ I have confirmed the above information with the patient. Additional comments:

_____

List previous hospitalizations/Surgeries/Serious Injuries	**Date**

Describe Current Tobacco Use: ☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Smoker – Status Unknown
☐ Former Smoker ☐ Never Smoker ☐ Unknown if Ever Smoked

Describe Alcohol Use: ☐ Never Use ☐ Monthly Use or Less ☐ 2 to 4 Times per Month
☐ 2 to 3 Times per Week ☐ 4 or More Times per Week ☐ Daily Use

Use of Drugs: ☐ Never Use Currently use the following Drugs:
☐ Daily Use ☐ Monthly Use or Less ☐ 2 - 3 times a Month
☐ 2 - 3 times per Week ☐ 4 or more times per week

Excessive Exposure At Home or Work To: ☐ Fumes ☐ Dust ☐ Solvents ☐ Noise

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

	Age	Disease	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Children			

CURRENT MEDICATION

List all medication that you are currently taking – including "Over-The-Counter" [OTC] medication(s).
Request additional paper if needed to complete list.

Medication	Check One	Dosage and Frequency	Reason Taken	(If Prescription Medication) Prescribed by
	Prescription ☐ OTC ☐			
	Prescription ☐ OTC ☐			
	Prescription ☐ OTC ☐			
	Prescription ☐ OTC ☐			
	Prescription ☐ OTC ☐			
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	Prescription ☐ OTC ☐			
	Prescription ☐ OTC ☐			
	Prescription ☐ OTC ☐			

MEDICATION ALLERGIES

Have you ever had an allergic reaction to medication: ☐ Yes ☐ No ☐Check if allergic to more than 8 meds

If "yes" -- List all medications and describe the allergic reaction you experienced below.

Name of Medication : Describe Reaction:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

OTHER ALLERGIES

List any OTHER allergies that you have:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Have you recently experienced any of the following?

CONSTITUTIONAL		**Date**
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
GENITOURINARY		
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
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

PLEASE ANSWER ALL QUESTIONS

MUSCULOSKELETAL		**Date**
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
PSYCHIATRIC		
Memory loss or confusion……	No	Yes
Nervousness……	No	Yes
Depression……	No	Yes
Sleep problems……	No	Yes
ENDOCRINE		
Glandular or hormone problem……	No	Yes
Thyroid disease……	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

☐ History was filled out by other than patient.

Name and Relationship:

_____

_____

Patient Signature: _____

☐ I have reviewed and confirmed this information with the patient.

Provider Signature:_____

Revised: September 2011; Update: 11/2011; 6/2014; 10/2014; 04/2017