WILLIS-KNIGHTON HEALTH SYSTEM

IDENTIFICATION DATA (Please print the following information)

Date _____ Age _____

Patient Name _____ Male___ Female____ Date of Birth _________

Address _____ Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

_____ Residence Phone ( )_____

_____ Business Phone ( )_____

FAMILY HISTORY − List Immediate family members who have died (Father, Mother, etc.):

_____

_____

_____

Circle Illnesses immediate family members have had:

Tuberculosis	Heart Disease	Hay Fever	Glaucoma
Diabetes	High Blood Pressure	Asthma	
Cancer	Allergies	Sickle Cell Anemia	

PATIENT HISTORY Please check if your medical history includes:

Date of last dental exam: _____

REVIEWER NOTES

EYE, EAR, NOSE
1. Hay Fever ____
2. Ear Infection ____
3. Hearing Loss ____
4. Eye Problems ____

GASTROINTESTINAL
5. Stomach Pain ____
6. Ulcers ____
7. Change In bowel Habits ____
8. Rectal Bleeding ____
9. Jaundice (Hepatitis) ____

CARDIO−RESPIRATORY
10. Trouble Breathing ____
11. Cough (If chronic) ____
12. Asthma ____
13. High Blood Pressure ____
14. Rheumatic Fever ____
15. Heart Disease ____
16. Activity Limitation ____
17. EKG−Last Date _____
18. Chest X−Ray − Date _____

GENITOURINARY
19. Difficulty starting stream ____
20. Night time urination ____
21. Kidney Disease ____
22. Urinary Infection ____

NEURO−MUSCULAR
23. Weakness ____
24. Numbness/Tingling ____
25. Muscle Pain ____
26. Seizures/Epilepsy ____
27. Paralysis ____
28. Migraine/Headaches ____

SKELETAL
29. Joint Pain or Swelling ____
30. Back Problems ____
31. Arthritis ____

ENDOCRINE
32. Diabetes ____
33. Thyroid Problems ____
34. Recent Weight Gain/Loss (10 pounds) ____

HEMATOLOGIC
35. Sickle Cell Disease ____
36. Anemia ____
37. Bleeding Tendencies ____
38. Thrombophlebitis/blood clots ____

OTHER (Additional space on back)
39. Cancer ____
40. Mental/Emotional Problems ____
41. Venereal Disease History ____
42. Tetanus Immunization
Last Date: _____

FOR WOMEN ONLY
43. Irregularity of Periods_____ 44. Abnormal Flow_____ 45. PID/Pelvic Pain_____ 46. Breast Disease____
47. Last Menstrual Period, Date:_____ 48. Last Pelvic/Pap Smear Date:_____
49. Birth Control? If so, what type:_____ 50. Number of Pregnancies:_____ Number of Births:_____

WILLIS-KNIGHTON HEALTH SYSTEM

IDENTIFICATION DATA continued

Patient Name _____ Date of Birth _________

Patient History. Cont'd.

PLEASE LIST ALL SURGERIES, HOSPITALIZATIONS, AND/OR SERIOUS INJURIES:

_____

_____

_____

PLEASE INCLUDE ALL CURRENT PRESCRIPTIONS, OVER THE COUNTER MEDS, HERBALS, PATCHES, INHALER, EYE DROPS & SUPPLEMENTS:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE NAME ANY DRUG ALLERGIES/ADVERSE REACTIONS:

_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT LIFE STYLE: Name your current occupation _____

	NO	YES
Do you use alcohol more than four times per week?	_____	_____
Do you smoke?	_____	_____
Do you ever use drugs recreationally?	_____	_____
Do you feel safe in your environment?	_____	_____

Indicate any abnormality	YES	NO	Description
A) Eyes	_____	_____	_____
B) Ears, Nose, Throat	_____	_____	_____
C) Skin	_____	_____	_____
D) Nervous System	_____	_____	_____
E) Chest	_____	_____	_____
F) Heart	_____	_____	_____
G) Abdomen	_____	_____	_____
H) Genito−Urinary System	_____	_____	_____
I) Pelvic	_____	_____	_____
J) Extremities	_____	_____	_____
K) Back	_____	_____	_____
L) Pain − Location	_____	_____	Pain Scale 0 1 2 3 4 5 6 7 8 9 10

Reviewed with patient by _____

Provider Signature Date/Time