Central Utah Clinic, PC
Your Health, Your Choice.℠

American Fork Internal Medicine
Jason Huddleston, DO

Today's Date: _____

Thank you for completing this Comprehensive History Form

Name: _____ Date of birth ____ / ____ / ____

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? _____

What were you doing when it started? _____

What other things happen with this problem? _____

_____

List previous hospitalizations/surgeries/serious injuries When/Age

_____

_____

_____

_____

_____

List other doctors who you see:

_____

_____

_____

List **allergies** you have:

_____

_____

_____

Medications/supplements/vitamins you've been taking:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have you and/or your family ever had the following?

	You	Mother	Father	Brother(s)	Sister(s)	Comments:
Diabetes	❑	❑	❑	❑	❑	
Heart Trouble	❑	❑	❑	❑	❑	
Hypertension	❑	❑	❑	❑	❑	
Lung problems	❑	❑	❑	❑	❑	
Cancer	❑	❑	❑	❑	❑	
Stroke	❑	❑	❑	❑	❑	
Arthritis/Gout	❑	❑	❑	❑	❑	
Convulsions	❑	❑	❑	❑	❑	
Bleeding Tendency	❑	❑	❑	❑	❑	
Acute Infections	❑	❑	❑	❑	❑	
Hereditary Defects	❑	❑	❑	❑	❑	
Mental Illness	❑	❑	❑	❑	❑	
Deceased		❑	❑	❑	❑	

Patient Social History: Who lives with you? ❑ Spouse ❑ I live alone ❑ other _____

What is your current occupation? _____ **or** ❑ Retired _____

Marital status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Other _____

Do you drink alcohol? ❑ Never ❑ Rarely ❑ Moderately ❑ Daily _____

Tobacco Use? ❑ Never **or** ❑ Yes, when? _____ How much/often? _____

Use of Drugs? ❑ Never ❑ Type/Frequency _____

Do you drink caffeinated beverages? ❑ Never ❑ Sometimes ❑ Quite often What kind? ❑ Coffee ❑ Soft Drinks

Have you had any problems of falling in the past year? ❑ No ❑ Yes/Describe _____

Do you feel safe at home? ❑ Yes ❑ No/Describe _____

*Are you **currently** experiencing any of the following? Please answer ALL questions!*

CONSTITUTIONAL
Recent weight change ..... No Yes
Fever ..... No Yes
Chills ..... No Yes
Fatigue ..... No Yes

EYES
Eye disease or injury..... No Yes
Wear glasses/contact lenses ..... No Yes
Blurred or double visions ..... 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

CARDIOVASCULAR
Heart trouble ..... No Yes
Chest pains..... No Yes
Sudden heart beat change..... 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 ..... No Yes
Vomiting..... No Yes
Diarrhea ..... No Yes
Blood in stool ..... No Yes
Stomach ..... No Yes

GENITOURINARY
Frequent urination..... No Yes
Burning or painful urination..... No Yes
Blood in urine..... No Yes
Change or 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: Last menstrual period _____
(date)

Do you have
pain with periods? ..... No Yes
irregular periods?..... No Yes
vaginal discharge? ..... No Yes
pregnancies _____ # miscarriages_____
date of last pap smear _____
last pap smear was ❑ 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
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
Headaches..... No Yes
Dizziness..... No Yes
Convulsions or seizures..... No Yes
Numbness or tingling ..... 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
Diabetes ..... No Yes
Hormone problems..... 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, glove or shoe 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
Hay fever or seasonal allergies..... No Yes

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, metholate or other antiseptics..... No Yes
Latex ..... No Yes

Patient Signature:_____

Physician Signature:_____