

GENERAL HISTORY FORM
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PATIENT: _____ DATE: _____ DOB: _____

REFERRING PHYSICIAN: _____ PRIMARY PHYSICIAN: _____

CURRENT COMPLAINT: _____ DATE OF ONSET: _____

PAST SURGERIES:

SURGERY: _____ DATE: _____

SURGERY: _____ DATE: _____

Please list additional surgeries on back of form

Do you take any medications? Yes No If yes, please list:

Do you have any drug allergies? Yes No If yes, please list:

Do you have a family history related to your symptoms? Yes No If yes, explain:

Do you use the following? Tobacco Alcohol Caffeine products

Marital Status: Single Separated Divorced Married Widowed

Are you pregnant? Yes No

REVIEW OF SYSTEMS:

Do you have a history of the following medical problems? If yes, check box:

High blood pressure Easy bruising/bleeding disorder Rheumatoid arthritis

Anemia Cancer Other (explain) _____

Do you have a history of heart problems? Yes No If yes, check box:

Heart attack Heart failure Abnormal heart rhythm

Other (explain) _____

Do you have a history of lung problems? Yes No If yes, check box:

Asthma Bronchitis Pneumonia Emphysema

Other (explain) _____

Do you have a history of digestive problems? Yes No If yes, check box:

Jaundice/hepatitis Black/tarry stool Abdominal pain Heartburn/indigestion

Food allergy Other (explain) _____

Do you have any urinary problems? Yes No If yes, check box:

Kidney problem Bladder problems Urinary infections

Other (explain) _____

Do you have any neurological problems? Yes No If yes, check box:

Seizures Stroke Fainting Other (explain) _____

Do you have any skin disorders? Yes No If yes, check box:

Skin cancer Melanoma Shingles Eczema Psoriasis

Other (explain) _____

Do you have any endocrine problems? Yes No If yes, check box:

Thyroid problems Diabetes Other (explain) _____

Do you have any immunologic problems? Yes No If yes, check box:

Dust, mold, or pollen allergy Difficulty fighting infection Swollen lymph glands

Other (explain) _____