Denton Combs

Center For Excellence In Care

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Patient Health History

PATIENT NAME ______________________________ DOB:__________ Age:________
(Last) (First) (Middle)

PCP/Referring Physician: ______________________________ Gender: ☐ Male ☐ Female

List any allergies to medications	Reaction

PAST HISTORY

ILLNESS	Date(s)	Y N	SURGERY	Date(s)	Y N	List any medications you are currently taking or provide list of medications:
Diabetes		☐ ☐	Abdominal		☐ ☐	
Blood or Clotting System		☐ ☐	Gallbladder		☐ ☐	
Cancer		☐ ☐	Appendix		☐ ☐	
Ear, Nose, Mouth Throat		☐ ☐	Thyroid		☐ ☐	
Heart Disease		☐ ☐	Rectal		☐ ☐	
High Blood Pressure		☐ ☐	Tonsils		☐ ☐	
High Cholesterol		☐ ☐	Hysterectomy		☐ ☐	
HIV		☐ ☐	Pregnancy		☐ ☐	
Kidney, Bladder		☐ ☐	Breast		☐ ☐	
Liver Disease / Hepatitis		☐ ☐	Other		☐ ☐	
Nervous System		☐ ☐				
Respiratory Problems/Tuberculosis		☐ ☐	Allergy Tests (blood)		☐ ☐	
Skin Disease		☐ ☐	Allergy Tests (skin)		☐ ☐	
Stomach, Intestine		☐ ☐				
Thyroid Gland		☐ ☐				

SOCIAL HISTORY

☐Y ☐N Do you / did you ever drink alcohol?

☐Y ☐N Do you / did you ever use tobacco? If Yes, Type: When did you stop:

☐Y ☐N Do you / did you ever use drugs?

☐Y ☐N Do you / did you ever use any nutritional supplements?

FAMILY HISTORY

Check (✓) if your blood relatives have had any of the following:

DISEASE	Y N	Relationship	DISEASE	Y N	Relationship
Cancer	☐ ☐		Bleeding Disorder	☐ ☐	
Diabetes	☐ ☐		Mental Illness	☐ ☐	
Heart Disease/High Blood Pressure	☐ ☐		Epilepsy	☐ ☐	
Thyroid	☐ ☐		Tuberculosis	☐ ☐	

PHARMACY NAME: **PHONE:**

REVIEW OF SYSTEMS Check (✓) symptoms you currently have:

CONSTITUTIONAL
- ☐ Fever
- ☐ Headache
- ☐ Chills
- ☐ Dizziness
- ☐ Weight Loss
- ☐ Bleeding/Bruising Easily

EYES
- ☐ Visual Disturbance
- ☐ Cataract
- ☐ Double Vision
- ☐ Trauma
- ☐ Glaucoma
- ☐ Eye Pain

ENT
- ☐ Hearing Loss
- ☐ Jaw Swelling
- ☐ Earache
- ☐ Dry Mouth
- ☐ Ringing in Ears
- ☐ Voice Changes
- ☐ Dizziness
- ☐ Nosebleed
- ☐ Ear Drainage
- ☐ Congestion
- ☐ Ear Swelling
- ☐ Nose Drainage
- ☐ Sore Throat
- ☐ Nose Pain
- ☐ Trouble Swallowing
- ☐ Swelling
- ☐ Toothache
- ☐ Nose Trauma

NECK
- ☐ Swollen Nodes
- ☐ Stiffness
- ☐ Pain
- ☐ Swelling
- ☐ Thyroid Problem
- ☐ Trauma

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Swelling
- ☐ Blood Clots

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Orthopnea
- ☐ Cough
- ☐ PND
- ☐ Hemophysis
- ☐ Chest Congestion

GI (Abdominal Symptoms)
- ☐ Nausea/Vomiting
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Gas/Bloating
- ☐ Diarrhea
- ☐ Bleeding

GU (Problems with Urination)
- ☐ Urination Problem
- ☐ Vaginal Discharge
- ☐ Blood in Urine
- ☐ Vaginal Bleeding
- ☐ Leg Pain
- ☐ Scrotal Pain/Swelling

MUSCULOSKELETAL
- ☐ Joint Pain
- ☐ Muscle Weakness
- ☐ Joint Swelling
- ☐ Muscle Pain

SKIN
- ☐ Rash
- ☐ Bruising
- ☐ Lesions
- ☐ Itching

NEUROLOGIC
- ☐ Seizure
- ☐ Loss of Consciousness
- ☐ Paralysis
- ☐ Disorientation
- ☐ Tremor
- ☐ Numbness Extremities

PSYCHIATRIC
- ☐ Confusion
- ☐ Anxiety
- ☐ Paranoia
- ☐ Insomnia
- ☐ Disorientation
- ☐ Mood Changes
- ☐ Depression

ENDOCRINE
- ☐ Growth Abnormalities
- ☐ Goiter
- ☐ Heat/Cold Intolerance
- ☐ Impotence
- ☐ Excessive Thirst/Hunger

HEMATOLOGY
- ☐ Bleeding
- ☐ Anemia
- ☐ Bruising

ALLERGY IMMUNOLOGY
- ☐ Hives
- ☐ Hay Fever
- ☐ Eczema
- ☐ Sensitivity to Food/Drugs/Pollen

OTHER:

GENERAL CONSENT FOR TREATMENT
I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instruction of Denton Combs, CNP, his assistants or his designee as is necessary in his judgement.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examinations by Denton Combs, CNP.

VERIFICATION
I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ Patient Signature

______________________________ Date