Patient's profile:
Chief complaint:
History of the present illness:
Systemic review:
Drug history:
History of allergy:
Past history:
Family history:
Socioeconomic history:

Patient's profile:

- Name: ____.
- Age: _____.
- Sex: ________.
- Marital Status: ______.
- Area of residence: _________________________________.
- Education: _____________. Occupation: _________________.
- Setting of Interview:
  - Place, Time & Date: ______________________________.

Chief Complaint:

What brought you to the hospital and why now?

- ____
- ____
- ____

History of Present illness:

- When the disease started? ___________________________.
- Onset? (Sudden, Gradual, Episodic)
- Course? (progressive, intermittent, decreasing)
- Site: ____.
- Radiation? ____.
- Severe? ___________.
- Frequency? _____________.
- Precipitating Factor(s): ____________________________.
- Aggravating Factor(s): _____________________________.
- Relieving Factor(s): _______________________________.
- Other Symptoms: ___________________________________.
- Risk Factors:______________________________________.

Systemic review:

General Symptoms:				
	Fever	☐ Yes	☐ No	___________
	Fatigue	☐ Yes	☐ No	___________
	General Weakness	☐ Yes	☐ No	___________
	Malaise	☐ Yes	☐ No	___________
	Appetite	☐ Yes	☐ No	___________
	Loss of Weight	☐ Yes	☐ No	___________

Systematic Symptoms:

Cardiovascular system:

▪ Chest Pain	☐ Yes	☐ No	▪ Palpitation	☐ Yes	☐ No
▪ SOB	☐ Yes	☐ No	▪ Ankle swelling	☐ Yes	☐ No
▪ Orthopnea	☐ Yes	☐ No	▪ Syncopal attack	☐ Yes	☐ No
▪ PND	☐ Yes	☐ No	▪ Intermittent Claudi.	☐ Yes	☐ No

Respiratory system:

Upper Respiratory Tract:

▪ Sneezing	☐ Yes	☐ No	▪ Sore throat	☐ Yes	☐ No
▪ N. Discharge	☐ Yes	☐ No	▪ Hoarseness voice	☐ Yes	☐ No
▪ Epistaxis	☐ Yes	☐ No	▪ Stridor	☐ Yes	☐ No
▪ N. Obstruct	☐ Yes	☐ No	▪ ______________	☐ Yes	☐ No

Lower Respiratory Tract:

▪ SOB	☐ Yes	☐ No	▪ Wheezing	☐ Yes	☐ No
▪ Cough	☐ Yes	☐ No	▪ Hemoptysis	☐ Yes	☐ No
▪ Sputum	☐ Yes	☐ No	▪ ______________	☐ Yes	☐ No

Gastrointestinal tract:

▪ Dysphagia	☐ Yes	☐ No	▪ Diarrhea	☐ Yes	☐ No
▪ Odyphagia	☐ Yes	☐ No	▪ Anal Pain	☐ Yes	☐ No
▪ Vomiting	☐ Yes	☐ No	▪ Anal Discharge	☐ Yes	☐ No
▪ Heartburn	☐ Yes	☐ No	▪ Anal Itching	☐ Yes	☐ No
▪ A. Pain	☐ Yes	☐ No	▪ Hematemesis	☐ Yes	☐ No
▪ A. Distention	☐ Yes	☐ No	▪ Hematochezia	☐ Yes	☐ No
▪ Constipation	☐ Yes	☐ No	▪ Melena	☐ Yes	☐ No

Urinary System:

▪ Renal Pain	☐ Yes	☐ No	▪ Stream of Micturition	☐ Yes	☐ No
▪ Dysuria	☐ Yes	☐ No	▪ Color of the Urine	☐ Yes	☐ No
▪ Frequency	___________.		▪ Amount of Urine	___________.	
▪ # Nocturnal	___________.		▪ ______________	☐ Yes	☐ No

Musculoskeletal System:

▪ Muscle Pain	☐ Yes	☐ No	▪ Limt. of movement	☐ Yes	☐ No
▪ Bone Pain	☐ Yes	☐ No	▪ Muscle wasting	☐ Yes	☐ No

- Swelling ☐ Yes ☐ No
- Deformities ☐ Yes ☐ No

Skin Symptoms:

- S. Rash ☐ Yes ☐ No
- Pain ☐ Yes ☐ No
- Itching ☐ Yes ☐ No
- Swelling ☐ Yes ☐ No
- S. Bleeding ☐ Yes ☐ No
- Change in Hair/Nails ☐ Yes ☐ No
- Discolor. ☐ Yes ☐ No

Genital Tract:

In Male:

- Erectile Dys. ☐ Yes ☐ No
- Ejaculation Prob. ☐ Yes ☐ No
- Urethral Dis. ☐ Yes ☐ No
- ______________. ☐ Yes ☐ No

In Female:

- Age of menarche/menopause: ______________.
- Regularity ☐ Yes ☐ No
- Amount of blood ☐ Yes ☐ No
- Mens. Pain ☐ Yes ☐ No
- Obstetric History: ____.

Neurological Symptoms:

- Headache ☐ Yes ☐ No
- Sleep Defect ☐ Yes ☐ No
- Fits ☐ Yes ☐ No
- Motor Defect ☐ Yes ☐ No
- Special sense ☐ Yes ☐ No
- Sensory Disturbance ☐ Yes ☐ No
- Speech Defect ☐ Yes ☐ No
- Level of Consciousness: ____________

Endocrinological symptoms:

- Sweating ☐ Yes ☐ No
- Cold/heat intolerance ☐ Yes ☐ No

Hematological:

- Pallor ☐ Yes ☐ No
- Recurrent fevers ☐ Yes ☐ No
- WBC Disturb. ☐ Yes ☐ No
- Bleeding tendency ☐ Yes ☐ No

Psychiatric Symptoms:

- Anxiety ☐ Yes ☐ No
- Traumatizing events ☐ Yes ☐ No
- Depression ☐ Yes ☐ No
- Fear of diseases ☐ Yes ☐ No
- Obsession ☐ Yes ☐ No
- Mental illnesses ☐ Yes ☐ No

Severity, frequency, duration, any relieving or precipitating factors and medications received

Drug history:

Drug:	Dose:	Frequency:	Duration:
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________

History of allergy:

- Allergy to medication: ☐ Yes ☐ No ________________.
- (Food, Pollen, other) ☐ Yes ☐ No ________________.

Past history:

- Similar attacks: ☐ Yes ☐ No ________________.
- Diseases in the same system ☐ Yes ☐ No ________________.
- Hospitalization ☐ Yes ☐ No ________________.
- Operations ☐ Yes ☐ No ________________.
- Major non oper. Trauma ☐ Yes ☐ No ________________.
- Severe acute illnesses ☐ Yes ☐ No ________________.
- Chronic illnesses ☐ Yes ☐ No ________________.
- Blood transfusion ☐ Yes ☐ No ________________.
- Vaccination ☐ Yes ☐ No ________________.
- Recent travel ☐ Yes ☐ No ________________.

Family history:

- Similar diseases ☐ Yes ☐ No ________________.
- Diseases in the same system ☐ Yes ☐ No ________________.
- Chronic illnesses in family ☐ Yes ☐ No ________________.
- Major acute illnesses recently ☐ Yes ☐ No ________________.

Socioeconomic history:

- Marital Status & Children: ________________.
- Level of Education: ________________.
- Income: ________.
- Living Circumstances: ________________.
- Recent Jobs: ________________.
- Hobbies: ________________.
- Smoking ☐ Yes ☐ No ________________.
- Alcohol Drinking ☐ Yes ☐ No ________________.
- Drug Abuse ☐ Yes ☐ No ________________.