PATIENT ENCOUNTER FORM (*Please fill out as completely as possible*)

Date: _____ **Drug Allergies:** _____

Name: _____ **Age:** _____

Referred by: _____

CHIEF COMPLAINT *(the main reason for your visit):* _____

HISTORY OF PRESENT ILLNESS *(history of this problem)*

- Location of problem _____
- Nature of problem _____
- Severity _____
- Duration (how long have you had these symptoms?) _____
- Timing (how often does it occur?) _____
- Modifying factors (does anything make it better or worse?) _____
- Associated signs and symptoms _____

DOCTOR'S HISTORY *(for physician notes only)*

_____

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS *(please check all that apply)*

General:	Fatigue	[ ]	**Nose:**	Obstruction	[ ]	**CV:**	Chest pain	[ ]
	Lethargy	[ ]		Drainage	[ ]		Palpitations	[ ]
	Weight loss	[ ]		Bleeding	[ ]	**Resp:**	Shortness of breath	[ ]
	Fevers	[ ]		Headaches	[ ]		Wheezing	[ ]
	Chills	[ ]		Sneezing	[ ]	**GI:**	Heartburn	[ ]
Eyes:	Eye pain	[ ]	**Throat:**	Pain	[ ]		Vomiting	[ ]
	Eye dryness	[ ]		Swallowing issue	[ ]		Abdominal pain	[ ]
	Visual problems	[ ]		Hoarseness	[ ]	**GU:**	Urinary difficulties	[ ]
Ears:	Ear pain	[ ]		Coughing	[ ]	**Neuro:**	Dizziness	[ ]
	Ear drainage	[ ]		Choking	[ ]		Memory loss	[ ]
	Vertigo	[ ]	**Neck:**	Pain	[ ]		Weakness	[ ]
	Tinnitus	[ ]		Masses	[ ]		Numbness	[ ]
Allergic:	Itchy eyes	[ ]	**MS:**	Bone/joint pain	[ ]	**Psych:**	Anxiety	[ ]
	Rashes	[ ]		Arm/leg difficulty	[ ]		Depression	[ ]

Other (please list)**:** _____

PAST MEDICAL HISTORY *(please complete as thoroughly as possible)*

- **Medical Problems** (past & present)**:** _____
- **Operations:** _____
- **Current Medications:** _____
- **Environmental Allergies:** _____
- **Family History** (significant illnesses in family members)**:** _____
- **Occupation/Work Environment:** _____
- **Smoking History:** _____ **Alcohol History:** _____

Patient Signature: _____ **Date:** _____