HISTORY FORM

In order to give you the highest quality care, please take a few minutes to complete the following questions about your MEDICAL HISTORY. This will become part of your permanent medical record. Thank you.

Name ____ Date: ____________________

CURRENT COMPLAINTS:
□ Headaches □ Neck Pain □ Arm Pain □ Arm/Hand Numbness □ Mid Back Pain □ Chest Pain □ Low Back Pain
□ Buttock Pain □ Hip Pain □ Leg Pain □ Leg/Foot Numbness □ Other: _______________________________

ONSET (How did your pain start?): □ Unknown □ Woke-up with it □ Bending □ Twisting □ Slip/Fall □ Accident

Explain:____
____
____

PAST MEDICAL HISTORY: Please check each box if you have had the following problems:

( ) Diabetes ( ) Stroke ( ) Heart Failure ( ) Arrhythmia ( ) Heart Attack ( ) Pacemaker
( ) Bypass ( ) Ulcer ( ) Dialysis ( ) Angioplasty ( ) Murmur ( ) Reflux
( ) Angina ( ) Headaches ( ) Leg Swelling ( ) Kidney Stones ( ) Hypertension ( ) Obesity
( ) Thyroid ( ) Arthritis ( ) Emphysema ( ) Tuberculosis ( ) Hemophilia ( ) Pneumonia
( ) Cancer – where? ( ) Pass Out ( ) Rheumatic fever ( ) Diverticulosis ( ) Hemorrhoids
______________________ ( ) Varicose Veins ( ) Impotence ( ) Cholesterol ( ) Asthma
______________________ ( ) Other ____
( ) Surgeries ____
____

FAMILY MEDICAL HISTORY:

Mother: Age: ________ ( ) Living ( ) Deceased
Father: Age: ________ ( ) Living ( ) Deceased
Siblings: Age: ________ ( ) Living ( ) Deceased

Please check each box with the appropriate letter if a family member has (had) the following problems (use M-Mother, F-Father, S-Sibling):

__ Diabetes __Stroke __Heart Failure __Arrhythmia __Heart Attack __Pacemaker
__Bypass __Ulcer __Dialysis __Angioplasty __Murmur __ Reflux
__Angina __Headaches __Leg Swelling __Kidney Stones __Hypertension __Obesity
__Thyroid __Arthritis __Emphysema __Tuberculosis __Hemophilia __Pneumonia
__Cancer – where? __Pass Out __Rheumatic fever __Diverticulosis __Hemorrhoids
______________________ __Varicose Veins __Impotence __Cholesterol __Asthma
______________________ __Other __________________________ __Allergies ________________
__Surgeries ____

CURRENT MEDICATIONS:

Name of Medicine	Strength	Dosage

List of known ALLERGIES: ____
____

( ) Tobacco ( ) Type: _______________
( ) Year begun: __________
( ) Still smoking
( ) Year quit: ____________
( ) Packs per day: ________

( ) Alcohol Type: ___________________
How often: _______________
How much: _______________
How many years: __________

( ) Exercise ( ) None ( ) light ( ) Moderate ( ) Heavy

Other:____
____
____
____

REVIEW OF SYSTEMS: Do you have (had) the following?:
Check the appropriate box(s)

GENERAL: □ Weight gain □ Weight loss □ Fever □ Hair loss
□ Weakness □ Other: ______________________________

EYES: □ Eye strain □ Wear glasses or contact lenses □ Sensitivity to light

EAR, NOSE,THROAT □ Ringing in ears □ Hearing loss □ Discharge or pain □ Dizziness
□ Runny nose □ Difficulty breathing through nose □ Sinusitis
□ Painful teeth, gums, or palate □ Growths in the mouth
□ Pain or difficulty swallowing □ Hoarseness

CARDIOVASCULAR □ Palpitations □ Chest pain □ Fainting □ Dizziness
□ Varicose veins □ Difficulty climbing Stairs □ Pain in the legs
□ Cold Feet/Hands □ Shortness of breath

RESPIRATORY □ Shortness of breath while walking □ Cough with or without phlegm
□ Asthma/Wheezing □ Spit up blood
□ Other: ______________________________

GASTROINTESTINAL □ Abdominal pain □ Nausea □ Vomiting □ Diarrhea
□ Hemorrhoids □ Change in shape or color of stool

GENITOURINARY □ Discharge □ Pain □ Frequent urination □ Pain with urination

MUSCULOSKELETAL □ Weakness □ Back Pain □ Neck Pain □ Leg Pain
□ Arm Pain □ Shoulder Pain □ Numbness □ Headaches
□ Other: ______________________________

SKIN □ Jaundice □ Dry skin □ Pigment Change □ Growths
□ Moles that have changed color, shape, or bleed

NEUROLOGIC □Tremors □ Weakness □ Numbness □ Memory Loss
□ Confusion □ Other: ______________________________

Name: ______________________________ Date: ____________________
File #: ____________________