Welcome to our practice. Please fill out the information below to the best of your ability.

Today's Date: _____

Patient's Name _____ Age _____ Date of Birth _____ M / F

Chief Complaint _____

PAST MEDICAL HISTORY

Have you ever had any of the following? Please check all pertinent boxes.

- ☐ Aids or HIV+
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Trouble
- ☐ Bladder Infections
- ☐ Bleeding Tendency
- ☐ Blood Transfusions
- ☐ Bronchitis
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcer

PAST SURGICAL HISTORY

Please list previous Hospitalizations / Surgeries / Serious Illnesses — When? — Hospital, City, State

_____

_____

_____

_____

MEDICATIONS

Please include non-prescription and Herbal Supplements

Drug Name	Dosage	Frequency	Drug Name	Dosage	Frequency

ALLERGIES

Medication	Reaction	Medication	Reaction

Tape Allergy ☐ Yes ☐ No **Latex Allergy** ☐ Yes ☐ No

FAMILY HISTORY

Things that members of your family have

- ☐ Back Pain
- ☐ Cancer
- ☐ Diabetes
- ☐ Drug/Alcohol Dependence
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Sudden Death
- ☐ Tuberculosis

PATIENT SOCIAL HISTORY

Marital Status
- ☐ Divorced
- ☐ Married
- ☐ Separate
- ☐ Single
- ☐ Widowed

Use of Alcohol
- ☐ Daily
- ☐ Moderate
- ☐ Never
- ☐ Rarely

Use of Tobacco
- ☐ Currently
- ☐ Never
- ☐ Previously, but quit

_____
Packs per day

Living Situation
- ☐ Alone
- ☐ Other

_____
- ☐ With Family
- ☐ With Friends

Dominant Hand
- ☐ Right
- ☐ Left

Date	Date	Date	Date	Date	Date
Patient	Patient	Patient	Patient	Patient	Patient
Doctor	Doctor	Doctor	Doctor	Doctor	Doctor

PATIENT HISTORY

The following questions pertain to symptoms the patient is experiencing or experiences on a regular basis. These questions pertain to the patient only:

CONSTITUTIONAL

Weight Loss	☐ YES	☐ NO
Fever	☐ YES	☐ NO
Night Sweats	☐ YES	☐ NO
Problems with Anesthesia	☐ YES	☐ NO

EYES:

Metal in Eye	☐ YES	☐ NO
Cataracts	☐ YES	☐ NO

ENT:

Nose Bleeds	☐ YES	☐ NO
Ear Ringing	☐ YES	☐ NO
Sore Throat	☐ YES	☐ NO
Hearing Loss	☐ YES	☐ NO

CARDIOVASCULAR:

Chest Pain	☐ YES	☐ NO
Leg Swell	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
Heart Murmur	☐ YES	☐ NO
Irregular Beat	☐ YES	☐ NO
Heart Attacks	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Blood Clot Lung/Legs	☐ YES	☐ NO

RESPIRATORY:

Irregular	☐ YES	☐ NO
Shallow	☐ YES	☐ NO
Cough	☐ YES	☐ NO
Shortness of Breath	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO

GASTROINTESTINAL:

Nausea/Vomiting	☐ YES	☐ NO
Change in Bowel Habits	☐ YES	☐ NO
Distension	☐ YES	☐ NO
Tarry Stools	☐ YES	☐ NO
Bloody Stools	☐ YES	☐ NO
Hepatitis	☐ YES	☐ NO

GENITOURINARY:

(Reproductive & Urinary Systems)

Frequency in Urination	☐ YES	☐ NO
Burning	☐ YES	☐ NO
Frequent Urination at Night	☐ YES	☐ NO
Frequent Infections	☐ YES	☐ NO
Bloody Urine	☐ YES	☐ NO
Inability to Control Bladder	☐ YES	☐ NO
Inability to Urinate	☐ YES	☐ NO
Prostate Problems	☐ YES	☐ NO

NEUROLOGICAL:

Fainting Spells	☐ YES	☐ NO
Seizures	☐ YES	☐ NO
Amnesia	☐ YES	☐ NO
Dizziness	☐ YES	☐ NO
Headache	☐ YES	☐ NO
Paralysis	☐ YES	☐ NO
Stimulator Implant	☐ YES	☐ NO

MUSCULOSKELETAL:

Back Pain	☐ YES	☐ NO
Neck Pain	☐ YES	☐ NO
Leg Pain	☐ YES	☐ NO
Joint Swelling	☐ YES	☐ NO
Fractures	☐ YES	☐ NO
Arm Pain	☐ YES	☐ NO

ENDOCRINE

Do you have diabetes?	☐ YES	☐ NO
Do you take insulin?	☐ YES	☐ NO
Hair Gain?	☐ YES	☐ NO
Hypoglycemia	☐ YES	☐ NO
Hyperglycemia	☐ YES	☐ NO

PSYCHIATRIC

Anxiety	☐ YES	☐ NO
Depression	☐ YES	☐ NO
Hallucinations	☐ YES	☐ NO
Difficulty Sleeping	☐ YES	☐ NO
Compulsive Behaviors	☐ YES	☐ NO
Impulsive Behaviors	☐ YES	☐ NO
Suicidal Ideation	☐ YES	☐ NO

HEME-LYMPH

Lightheadedness	☐ YES	☐ NO
Easy Bleeding	☐ YES	☐ NO
Easy Bruising	☐ YES	☐ NO
Petechiae	☐ YES	☐ NO
Purpura	☐ YES	☐ NO
Lymph Node Enlargement	☐ YES	☐ NO
Pica	☐ YES	☐ NO

ALLERGIC-IMMUNOLOGICAL

Sinus Allergy Symptoms	☐ YES	☐ NO
Allergic Dermatitis	☐ YES	☐ NO
Frequent Illness	☐ YES	☐ NO

PLEASE USE THIS SPACE TO LIST ANY INFORMATION THAT HAS NOT BEEN MENTIONED ABOVE THAT YOU FEEL WOULD BENEFIT THE DOCTOR IN HIS TREATMENT OF YOUR CASE.

_____

_____

_____