

**CURRENT MEDICAL HISTORY**

Patient name \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Who referred you? \_\_\_\_\_

Family Physician \_\_\_\_\_ Doctor's Phone \_\_\_\_\_

Address of family physician \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What are your Major Concern(s) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your Other Concerns and when did they start \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did your major concern(s) begin (be specific) \_\_\_\_\_

\_\_\_\_\_

**Pain and Problem History:**

What seemed to really start it? If it was an injury, how did it happen? \_\_\_\_\_

\_\_\_\_\_





What do you do that makes it better or improves your symptoms? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you do that makes it feel worse? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List the weather conditions you feel best in: \_\_\_\_\_

List the weather conditions you feel worst in: \_\_\_\_\_

**DIAGNOSTIC TESTING**—Please bring a paper copy of test reports, and the actual films of plain x-rays if possible.

***Don't copy the test report into this table.***

<b>TEST NAME</b>	<b>DATE TEST was DONE</b>	<b>FACILITY where test was DONE</b>	<b>WHAT RESULTS WERE YOU TOLD?</b>

--	--	--	--

**What SURGERIES have you had?**

SURGERY	DATE	REASON for SURGERY	SUCCESSFUL?

Continue on separate sheet of paper if needed.

**REVIEW OF SYSTEMS**

Please check any symptoms that are bothersome to you NOW.

**General**

<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Bleed/bruise easily	<input type="checkbox"/> Poor balance	<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Fevers
<input type="checkbox"/> Poor sleeping	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Sweat easily	<input type="checkbox"/> Chills
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Strong thirst	<input type="checkbox"/> Localized weakness	<input type="checkbox"/> Tremors	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Cravings for:	<input type="checkbox"/> Sweets	<input type="checkbox"/> Fats	<input type="checkbox"/> Salty food	<input type="checkbox"/> Other _____

**Skin & Hair**

<input type="checkbox"/> Rashes	<input type="checkbox"/> Loss of hair	<input type="checkbox"/> Pimples	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Recent moles	<input type="checkbox"/> Excema	<input type="checkbox"/> Hives
<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Itching	<input type="checkbox"/> Change in hair	<input type="checkbox"/> Change in skin	<input type="checkbox"/> Herpes	<input type="checkbox"/> Finger nails chip/crack/peel	<input type="checkbox"/> Other

**Cardiovascular**

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Chest pains	<input type="checkbox"/> Irregular heartbeat
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Fainting	<input type="checkbox"/> Cold hands	<input type="checkbox"/> Cold feet
<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Swelling feet	<input type="checkbox"/> Swelling hands	<input type="checkbox"/> Blood clots
<input type="checkbox"/> Difficulty breathing	Other _____		

**Head, Eyes Ears Nose & Throat**

<input type="checkbox"/> Concussions	<input type="checkbox"/> Jaw clicks (TMJ) L or R	<input type="checkbox"/> Tooth problems	<input type="checkbox"/> # of teeth pulled
--------------------------------------	--	---	--

___ # of silver fillings	___ # Root canals	___ Eye pain	___ Poor vision
___ Migraine	___ Other headache	Type of headache _____	___ Sores on lips/tongue
___ Sinus problems	___ Nose bleeds	___ Spots in front of eyes	___ Trouble with night vision
___ Grinding teeth	___ Facial pain	___ Trouble with taste or smell	___ Glasses
___ Ear aches	___ Cataracts	Other _____	

Rheumatoid disease? ___Y ___N	Tested for Lyme disease? ___Y ___N	Diabetes? ___Y ___N	Thyroid problems? ___Y ___N
Cancer? ___Y ___N What Kind _____	Hepatitis? ___Y ___N What Kind _____	AIDS? ___Y ___N	Breast implants? ___Y ___N What Kind _____
Other communicable disease? _____			

### Immunology

### Respiratory

___ Cough	___ Shortness of breath with minimal exercise	___ Difficulty breathing when lying down	___ Pain with deep breath
___ Coughing blood	___ Pneumonia	___ Asthma	___ Shortness of breath
___ Bronchitis	Other _____		

### Gastrointestinal

___ Nausea	___ Abdominal pain/cramps	___ Indigestion	___ Hemorrhoids	___ Constipation
___ Vomiting	___ Diarrhea	___ Black stools	___ Belching	___ Gas
___ Rectal pain	___ Blood in stools	___ Bad breath	___ Heartburn	___ Pancreatitis
How many bowel movements a day _____	How many bowel movements a week _____	Other _____		

### Genitourinary

___ Pain with urination	___ Frequent urination	___ Blood in urine	___ Urgency to urinate
___ Unable to hold urine	___ Kidney stone #: ___	___ Decrease in flow	___ Wake up to urinate
___ Problem with sexual function	___ Impotency	___ Loss of libido (desire)	___ Pain with intercourse
___ Sexually transmitted disease or exposure	___ Sores on genitals	Other:	

### Pregnancy & Gynecology

Pregnant? ___Y ___N	Planning a pregnancy? ___Y ___N	Post menopausal? ___Y ___N	Menopause symptoms? ___Y ___N
First date of last menses: _____	Unusual character (heavy/light)	Hot flashes? ___Y ___N	Fibrocystic breast ___Y ___N
___ Clots	___ Painful periods	___ Irregular periods	___ Vaginal discharge
___ Vaginal sores	___ Breast lumps	Birth control ___Y ___N	Type of birth control :
# of children: _____	# of C-section delivery(s) _____	# of vaginal delivery(s) _____	# of abortion(s) _____

Ages of children _____	_____	_____	_____
------------------------	-------	-------	-------

**Musculoskeletal**

<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Jaw pain	<input type="checkbox"/> Face pain	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Elbow pain	<input type="checkbox"/> Arm pain	<input type="checkbox"/> Wrist pain	<input type="checkbox"/> Hand pain
<input type="checkbox"/> Finger pain	<input type="checkbox"/> Upper back pain	<input type="checkbox"/> Lower back pain	<input type="checkbox"/> Hip pain	<input type="checkbox"/> Thigh pain
<input type="checkbox"/> Knee pain	<input type="checkbox"/> Leg pain	<input type="checkbox"/> Ankle pain	<input type="checkbox"/> Foot pain	<input type="checkbox"/> Toe pain
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Other: _____	_____

**Neuropsychological**

<input type="checkbox"/> Seizures	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Lack of coordination
<input type="checkbox"/> Poor memory	<input type="checkbox"/> Concussion	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Bad temper	<input type="checkbox"/> Easily susceptible to stress	<input type="checkbox"/> Treated for emotional problems	<input type="checkbox"/> Aneurysm
Ever considered suicide? <input type="checkbox"/> Y <input type="checkbox"/> N	Ever attempted suicide? <input type="checkbox"/> Y <input type="checkbox"/> N	Areas of numbness? <input type="checkbox"/> Y <input type="checkbox"/> N	Where?
Other _____			

**Other information you think is important that did not come up during review of systems:**

---



---



---



---



---



---



---



---



---



---

**Family History**

	<b>Father</b>	<b>Mother</b>	<b>Father's pare</b>	<b>Mother's parent</b>	<b>Siblings</b>	<b>Children</b>
--	---------------	---------------	--------------------------	----------------------------	-----------------	-----------------

			<b>nts</b>	<b>s</b>		
<b>Heart disease</b>						
<b>High Blood pressure</b>						
<b>Stroke</b>						
<b>Cancer</b>						
<b>Glaucoma</b>						
<b>Diabetes</b>						
<b>Epilepsy/seizures</b>						
<b>Bleeding disorder</b>						
<b>Kidney disease</b>						
<b>Thyroid disease</b>						
<b>Mental illness</b>						
<b>Osteoporosis</b>						
<b>Fibromyalgia</b>						
<b>Other</b>						

### **Additional History**

Childhood illnesses: \_\_\_\_\_

Childhood accidents and any lasting effects: \_\_\_\_\_



---

---

---

---

---

Environmental allergies—list agent and reaction:

---

---

---

---

---

History of allergy testing and treatment:

---

---

---

---

---

---

Have you ever smoked Tobacco? Y N      How many packs per day? \_\_\_\_\_ Now ? \_\_\_\_\_

How many years a smoker? \_\_\_\_\_ How many times did you quit? \_\_\_\_\_ When? \_\_\_\_\_

---

---

---

---

**Do you have a history of alcohol or drug abuse? Treatment for abuse? Please explain:** \_\_\_\_\_

---

---

---

---

---

---

---

**Diet:**

red meat — number of meals per week \_\_\_\_\_

milk — number of glasses per week \_\_\_\_\_ or per day \_\_\_\_\_

cheese — number of times per week \_\_\_\_\_ or per day \_\_\_\_\_

coffee or tea — number of cups per week \_\_\_\_\_ or per day \_\_\_\_\_.

soda — number of cans per week \_\_\_\_\_ or per day \_\_\_\_\_,

what kind usually? \_\_\_\_\_

\_\_\_\_\_

other sugar — what sweets do you usually eat and how much? \_\_\_\_\_

---

---

bread — what kind and how much? \_\_\_\_\_

which do you use margarine or butter? \_\_\_\_\_

what cooking oils do you use? \_\_\_\_\_

what are your favorite foods? \_\_\_\_\_

---

---

---

**Vitamins: what do you take, and why ( only list why for unusual supplements or herbs )?**

---

---

---

---

---

Sleep: how well do you sleep? \_\_\_\_\_

If not well, why not? \_\_\_\_\_

---

---

---

What position do you sleep in? \_\_\_\_\_

---

---

Do you use a pillow? what kind? where placed? \_\_\_\_\_

---

---

---

Do you have stomach sensitivity to aspirin? \_\_\_\_Y \_\_\_\_N

Do you have irritable bowel? \_\_\_\_\_ for how long? \_\_\_\_\_

---

How is this treated? \_\_\_\_\_

---

---

Who is the treating doctor? \_\_\_\_\_

Do you have a history of ulcer or indigestion? \_\_\_\_Y \_\_\_\_N please explain: \_\_\_\_\_

---

---

---

---

How is this treated and who is the doctor? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When was your last complete physical examination? \_\_\_\_\_  
\_\_\_\_\_

For what reason? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your occupation? \_\_\_\_\_ What was your occupation? \_\_\_\_\_

If you are disabled, when did you last work? \_\_\_\_\_

What is your disability caused by? \_\_\_\_\_

Anything else you would like us to know? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your goals for this treatment? What do you expect to be able to change?  
with regard to your pain and your life? If you are not working, do you plan to return to work, and how soon?  
How hard are you willing to work to reach your goals?

---

---

---

---

---

---

---

---

---

---

*To the best of my knowledge, this is complete and accurate.*

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_