

Skim through entire form before starting to fill this out.

Please Print

CURRENT MEDICAL HISTORY

Long answers may be continued on the back of any sheet.

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? _____

List the weather conditions you feel best in: _____

List the weather conditions you feel worst in: _____

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

Lab tests, Blood tests, MRI scan reports, CT scan reports, EMG reports, etc.

Do not copy the test report into this table.

TEST NAME	DATE TEST was DONE	FACILITY where test was DONE	WHAT RESULTS WERE YOU TOLD?

What SURGERIES have you had?

SURGERY	DATE	REASON for SURGERY	SUCCESSFUL?

REVIEW OF SYSTEMS

Please check any symptoms that are bothersome to you NOW.

General

<input type="checkbox"/> Poor appetite	<input type="checkbox"/> 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"/> 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"/> Blood clots	<input type="checkbox"/> Swelling hands	<input type="checkbox"/> Swelling feet
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Previous heart attack	<input type="checkbox"/> Other _____	_____

Head, Eyes, Ears, Nose & Throat

<input type="checkbox"/> Concussions	<input type="checkbox"/> Jaw clicking (TMJ) L or R	<input type="checkbox"/> Tooth problems	<input type="checkbox"/> # of teeth pulled
Silver fillings? Yes or No	<input type="checkbox"/> # of silver fillings	Root canals? Yes or No	<input type="checkbox"/> # of root canals
<input type="checkbox"/> Eye pain L or R	<input type="checkbox"/> Poor vision	<input type="checkbox"/> Trouble with night vision	<input type="checkbox"/> Spots in front of eyes
<input type="checkbox"/> Migraine headache	<input type="checkbox"/> Other kind of headache	What kind(s)? _____	<input type="checkbox"/> Mouth sores
<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Facial pain	<input type="checkbox"/> Trouble with taste	<input type="checkbox"/> Trouble with smell
<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Glasses	Other _____

Immunology

Rheumatoid disease? Yes No	What kind? _____	Diabetes? Yes No	Thyroid problems? Yes No
Cancer? Yes No	What kind? _____	Hepatitis? Yes No	Adrenal problem? Yes No
Breast implants? Yes No	What kind? _____	What kind of hepatitis?	_____
Cancer? Yes No	What kind? _____	Other communicable disease?	_____
Lyme disease? Yes No	Tested for lyme? Yes No	HIV? Yes No	Test positive? or Disease?

Respiratory

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

Gastrointestinal

___ Nausea	___ Abdominal pain/cramping	___ Indigestion	___ Hemorrhoids	___ Vomiting
___ Constipation	___ Number BM's per day or per week	___ Diarrhea	___ Black stools	___ Belching
___ Gas	___ Rectal pain	___ Blood in stools	___ Bad breath	___ Heartburn
___ Pancreatitis	___ Other _____			

Genitourinary

___ Pain with urination	___ Frequent urination	___ Blood in urine	___ Urgency to urinate
___ Unable to hold urine	___ Kidney stone(s)	How many attacks? _____	___ Decrease in flow
___ Problem with sexual function	___ Impotency	___ Loss of libido (desire)	___ Wake up to urinate
___ Pain with intercourse	___ Sexual disease exposure	___ Sexually transmitted disease	___ Other _____

Pregnancy and Gynecology

Pregnant? Yes No	Planning to get pregnant? Y N	___ Post menopausal	___ Menopause symptoms
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	
Number of children _____	# of C-section deliveries: _____	# of vaginal deliveries _____	# of abortions: _____
Ages of children: _____	_____	Type of birth control: _____	_____

Musculoskeletal

___ Muscle pain	___ Muscle weakness	___ Jaw pain	___ Face pain	___ Neck pain
___ Shoulder pain	___ Elbow pain	___ Arm pain	___ Wrist pain	___ Hand pain
___ Finger pain	___ Upper back pain	___ Lower back pain	___ Hip pain	___ Thigh pain
___ Knee pain	___ Leg pain	___ Ankle pain	___ Foot pain	___ Toe pain
___ Osteoporosis	___ Scoliosis	___ Other: _____	_____	___ Chest pain

Additional History

Childhood illnesses: _____

Childhood accidents and any lasting effects: _____

Current medications

Current medications	Who prescribed them	What are they for?	Are they helpful?

Pharmacy

Current pharmacy: _____

Address or location: _____

Phone: _____

Allergies to medication and environment:

Medication allergies—list medicine and reaction:

Environmental allergies—list agent and reaction:

History of allergy testing and treatment:

Have you ever smoked Tobacco? Y N. How many packs per day? _____

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: _____ what kind? _____

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? _____

What are your symptoms? _____

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: _____

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:** _____