

PATIENT HEALTH HISTORY

Name _____

 Male Female

Age: _____ Weight: _____ Height: _____

 Right / Left Handed

Your symptoms are the result of the following:

- Work Incident Date: _____
 Auto Accident Date: _____
 Other Liability Date: _____

Are you currently working? Yes No
 If not, last day worked: _____
 Is there litigation pending? Yes No

 Describe your symptoms: _____

Date of onset of symptoms: _____

PRIOR TREATMENT:

- Physical Therapy Yes No How Long? _____ Epidural Injections Yes No
 Chiropractor Yes No How Long? _____ Non-Steroidals/Anti-inflammatories Yes No
 Oral Steroids Yes No Pain Medications Yes No

Referring Physician: _____ Address: _____

Family Physician: _____ Address: _____

Other Physician you would like to receive a report of findings:

Name: _____ Address: _____

PAST MEDICAL HISTORY:

- | | | |
|---|---|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression/Psychiatric |
| <input type="checkbox"/> Heart Problems:
CHF, Angina, Heart Attack | <input type="checkbox"/> Stomach Problems:
Ulcers, GERD | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Lung Problems:
Asthma, Emphysema, TB,
Pneumonia | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Thyroid disorder |
| | <input type="checkbox"/> Seizures | <input type="checkbox"/> Excess bleeding |

List ALL surgeries and when they were performed:

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

 Any difficulty or problems with anesthesia? Yes No

If Yes, what type of difficulty (or reaction) did you have? _____

List all medications you are taking including birth control pills and vitamins/supplements:

<u>Medication</u>	<u>Dosage/Frequency</u>
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medications? Yes No

If yes, please list medication and reaction: _____

Are you allergic to: Latex? Yes No Iodine? Yes No Shellfish? Yes No

SOCIAL HISTORY:

Do you smoke? Yes No If yes, how much? _____

Do you drink alcohol? Yes No If yes, how much? _____

Do you use illicit drugs? Yes No

Marital Status: Married Single Divorced Separated Widowed

Occupation: _____

FAMILY HISTORY:

- Brain Tumor
- Cancer (excluding brain cancer)
- Aneurysm
- Stroke
- Diabetes
- Heart Attack

REVIEW OF SYSTEMS: Check only those you **currently** have

GENERAL SYMPTOMS

- Tired, weak, lack of energy
- Depression, moodiness
- Weight loss (unexplained)
- Sleeplessness or too much sleep
- Frequent colds or other illness
- Headaches
- Dizziness, fainting, blacking out
- Do not sweat enough or too much
- Night sweats

HEENT:

- Visual loss
- Double vision
- Cold sores or herpes
- Loss of smell or taste
- Bleeding gums
- Hoarseness
- Hearing loss
- Dental problems
- Difficulty swallowing

GASTROINTESTINAL

- Loss of appetite
- Nausea or vomiting
- Heartburn
- Indigestion
- Constipation
- Diarrhea
- Blood in stool or on paper

CARDIOVASCULAR

- Fast/irregular heart beats
- Tightness in chest
- Dizzy or weak on standing
- Swollen feet, ankles or legs
- Leg pain with walking
- High blood pressure
- Low blood pressure

REVIEW OF SYSTEMS Cont'd: Check only those you **currently** have

URINARY

- Difficulty urinating
- Urinate frequently at night
- Bed wetting
- Kidney stones
- Pain when urinating

ENDOCRINE

(Female)

- Intolerance to cold/heat
- Irregular periods
- Nipple discharge
- Hot flashes
- Inability to conceive

(Male)

- Intolerance to cold/heat
- Nipple discharge
- Prostate problems
- Sexual difficult
- Pain in genital
- Painful testicles

Have you ever had the following tests in the past twelve (12) months?

- | | | | |
|------------------------------------|-------------|---------------------------------|-------------|
| <input type="checkbox"/> CT Scan | Date: _____ | <input type="checkbox"/> EMG | Date: _____ |
| <input type="checkbox"/> MRI | Date: _____ | <input type="checkbox"/> EEG | Date: _____ |
| <input type="checkbox"/> Myelogram | Date: _____ | <input type="checkbox"/> X-rays | Date: _____ |
| <input type="checkbox"/> Other | Date: _____ | | |

I certify that the above information is correct to the best of my knowledge.

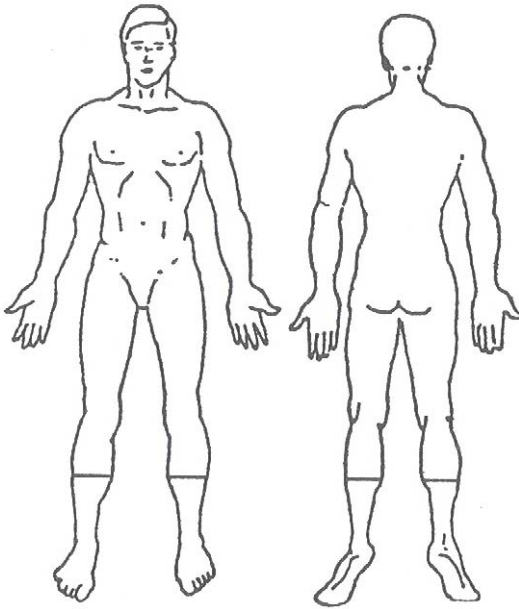
Signature: _____ Date: _____

Print Name: _____

Physician Signature: _____ Date: _____ Time: _____

PHYSICIAN NOTES:

Please Shade the location of your pain:



Have you experienced any weakness in your affected areas? _____

Do you experience any tingling and numbness? If so, where? _____

Please Shade the location of your numbness/tingling (i.e., pins and needles)

