MEDICATIONS

List all current medications (taking at this time.) (prescription or over the counter)

Name of Medication	Dose	Frequency	Reason taking	Last date taken

Supplements ____

____

____

CHIEF COMPLAINTS

Reason for evaluation:

Why do you need treatment?

(Example) - such as pain in the neck, back, shoulders, knee, headaches

1. ____
2. ____
3. ____
4. ____
5. ____

HISTORY OF PRESENT ILLNESS

Please give a narrative description of your illness from beginning to the present. Try to give it in sequence as close as you can (chronological order). Include injuries, surgeries, treatment by a doctor, treatment you did on your own. Describe any effects on you, your job, family, finances if any.

FAMILY HISTORY

Father   Living? _____Yes ______No ______Age   Health Condition____________________________

If Deceased Age of Death ______   Cause ______________________________

Mother   Living? _____Yes ______No ______Age   Health Condition____________________________

If Deceased Age of Death ______   Cause ______________________________

Has any family member ever had any of the following? If so, who?

O alcoholism ____

O anemia (low blood) ____

O anesthesia reaction ____

O allergies ____

O arthritis ____

O cancer ____________________type ______age ________________________

O chronic back pain ____

O chronic lung disease ______type ______smoker ____________________________

O chronic neck pain ____

O depression ____

O diabetes ____

O drug allergy ______________ which ____

O drug abuse ____

O epilepsy (seizures, fits, convulsions) ____

O gout ____

O hepatitis ____

O heart attack ____

O hemophiliac (free bleeder) ____

O high blood pressure ____

O other heart disease ________________

O osteoporosis ________________

O psychiatric disorder ________________

O chronic kidney problem ________________

O lupus ________________

O stomach ulcers ________________

O tuberculosis ________________

O stroke ________________

SOCIAL HISTORY

Education – highest level attended

O grade school O middle school O high school

O GED O vocational tech school O college

O graduate school

Marital Status

O married O single O divorced

O widowed O children ______ number

Habits

O smoking ______ pack(s)/day ______years O quit ____________ when

O alcohol O never O rarely

O occasionally O regularly ______________quantity

O intravenous drug use O drugs O occasionally

O frequently which________________________

O drug abuse treatment when ________________________

O exercise regularly O yes O no

Employment/Occupation

Current/previous occupation ____________________ unemployed __________ retired _______

Do you feel your pain may be related to your work? O yes O no

How? ____

______current worker compensation case open

______on disability duration ______ reason ______________________

When did you last work? ______________________________________

Type of work last done? ______________________________________

Previous types of work done____________________________________

Are you able to do household chores? O yes O no

How many hours per week do you work at your present job ______________________

Current work restrictions if any. ______________________________

SURGICAL HISTORY/INJURIES

List all surgeries/injuries as close as possible in order starting with the first surgery/injury.

Surgery________________________________ Approximate date______________

Surgery________________________________ Approximate date______________

Surgery________________________________ Approximate date______________

Surgery________________________________ Approximate date______________

Surgery________________________________ Approximate date______________

Injury ________________________________ Approximate date______________

Injury ________________________________ Approximate date______________

Injury ________________________________ Approximate date______________

Injury ________________________________ Approximate date______________

Injury ________________________________ Approximate date______________

Injury ________________________________ Approximate date______________

HOSPITALIZATIONS

In order as close as possible, starting with the first.

Reason for Hospitalization ______________________ Approximate date________________

Reason for Hospitalization ______________________ Approximate date________________

Reason for Hospitalization ______________________ Approximate date________________

Reason for Hospitalization ______________________ Approximate date________________

Reason for Hospitalization ______________________ Approximate date________________

REVIEW OF SYSTEMS

Check any problems that you have or have had in the past;

General

- O fatigue
- O trouble falling asleep
- O restless sleep
- O difficulty getting up in the morning
- O fever
- O chills
- O unexplained bleeding
- O night sweats
- O contagious illness
- O AIDS
- O MRSA
- O recent weight change

  maximum weight ____________ when? ________________

  minimum weight ____________ when? ________________

- O other ____

Skin

- O dry skin
- O skin color change
- O rash
- O dry hair
- O change in hair/nails
- O yellow complexion
- O itching
- O unexplained/excessive hair
- O eczema
- O psoriasis
- O peeling/brittle nails
- O pitted nails
- O spider bite
- O skin cancer type ______________________
- O other ____

Head/Face

- O acne
- O puffy faces
- O facial paralysis
- O migraines

Eyes

- O blurred vision
- O double vision
- O glasses/contacts
- O cataracts
- O glaucoma
- O injury
- O dry eyes

Ear/Nose/Throat/Mouth

- O ear infection
- O bleeding gums
- O frequent sore throat
- O hoarse voice
- O sinus infection
- O mouth sores
- O nose bleeds
- O dentures
- O bad breath
- O dry mouth
- O tongue feels too big for mouth (thick tongue)
- O difficulty swallowing
- O hearing loss
- O other ____

Neck

- O masses
- O enlarged thyroid
- O swollen glands
- O pain
- other ______________________________

ENDOCRINE

O high thyroid O low thyroid O recurring infections
O sleeping with socks on O high blood pressure O hardening of arteries
O overweight/underweight O difficulty loosing weight
O excessive sweating O decreased sweating O low blood sugar
O low body temperature O poor exercise tolerance
O falling asleep after dinner O need for frequent naps in evening
O overly sensitive to hot/cold O unexplained loss of eyebrow hair
O decreased sex drive (desire, libido)
O always having cold hands/feet
O diabetes - type____________________ age onset __________

CHEST/BREAST

O breast lump O breast implants O breast pain
O breast discharge O breast masses
O fibrocystic breast problems O other ______________________________

CARDIOVASCULAR

O chest pain O trouble breathing O blood clots
O fast heart beat O irregular heart beat
O heart murmur O leg cramps O poor circulation
O high blood pressure O stroke O heart valve problem
O pacemaker O heart attack
O episodes of painful color changes – hands/feet
O cold extremities – hands/feet
O other ____

RESPIRATORY

O wheezing O cough O difficulty breathing

O tuberculosis O emphysema O asthma

O pain with deep breath O shortness of breath with exertion/exercise/other

GASTROINTESTINAL

O heart burn/indigestion O stomach ulcers O constipation

O bowel movement changes How many BM's/day do you have? ____________

O blood in stool O black stools O hemorrhoids

O pain with bowel movement O recurrent diarrhea O difficulty swallowing

O reflux disease O hepatitis O cirrhosis

O umbilical hernia O groin hernia O hiatal hernia

O other ____

GENITOURINARY

O pain with urination O difficulty starting/stopping urination

O blood in urine O leaking urine O genital rash/ulcers

O difficulty getting/keeping erections O painful periods

O sexual desire problems O heavy periods O ovarian cysts

O bladder infection O kidney infection O prostate infection

O enlarged prostate O pregnancy problems

O age first period ________ O age last period ________

MUSCULOSKELETAL/EXTREMITIES

O chronic/recurrent pain lower extremities

O chronic/recurrent back pain O chronic/recurrent pain upper extremities

O chronic/recurrent neck pain O numbness/tingling in arms

O numbness/tingling in legs O walking with a limp

O excessive stiff muscles/joints – (takes effort to get limber after being inactive

O walking with a cane/walker O weak joints - which? ____________________

O weak muscles -which? ____________________

LYMPHATIC/BLOOD

O anemia (low blood)	O elevated blood count	O fluid retention (swelling)
O unexplained bruises	O unexplained bleeding	O enlarged glands
O slow healing of cuts/wounds	O slow recovery from an illness	
O leukemia	O other ____________________	

NEUROLOGICAL

O seizures/convulsions/fits/epilepsy		O numbness/tingling
O frequent/recurrent headaches	O tremors/shakes	O dizziness
O lightheaded	O depression	O anxiety
O memory loss	O poor memory	O forgetfulness
O thinking not clear (brain fog)	O episodes of confusion	O short attention span
O difficulty staying focused	O slow reflexes	O peripheral neuropathy
O frequent feelings of sadness	O grumpy	O irritable
O mood swings	O ADD/ ADHD	O neuropathy

O other ____________________

ALLERGIES

O Allergic reaction to medications - which? ____________________

O Novocain	O shellfish	O IV dye
O aspirin	O anesthesia	O steroids