CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records.

Name _____ Birthdate _____ Sex □ M F

Address _____City _____ State_____ Zip _____

Soc.Sec. # _____ Home Phone _____ Work _____

Cell _____ E-Mail _____

Marital Status: □ M □ S □ D □ W Children, Ages _____ Spouse's Name _____

Race: □Asian □Black or African American □White □Native American □Pacific Island □Other_____

Ethnicity: □Caucasian □Black or African American □Hispanic/Latino □Other_____

Occupation _____ Employer _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major complaint? _____

_____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: □ Improved □ Unchanged □ Getting Worse

Is this condition interfering with your: □ Work □ Sleep □ Daily Routine Other _____

Other doctors or therapists who have treated THIS condition _____

When was the last time you saw that doctor for the condition?_____

What do you think caused this condition? _____

List surgical operations and years: _____

_____

Do you have a family physician? Name _____

Medications, dosage and frequency: _____

_____

Have you been in an auto accident or had any other personal injury? □ Y □ N Describe _____

_____

Signature _____ Date _____

Parent/Guardian _____ Date _____

Patient Name_____ Number _____ Date _____

REVIEW OF SYSTEMS Check only the ones you NOW have or have had in the PAST

GENERAL	Now	Past
Weakness	□ N	□ P
Fatigue	□ N	□ P
Fever	□ N	□ P
Chills	□ N	□ P
Night Sweats	□ N	□ P
Fainting	□ N	□ P
SKIN		
Color Changes	□ N	□ P
Nail Changes	□ N	□ P
Hair Changes	□ N	□ P
Moles	□ N	□ P
Rashes	□ N	□ P
Sores	□ N	□ P
Weakness	□ N	□ P
HEAD		
Headaches	□ N	□ P
Injuries	□ N	□ P
Bumps	□ N	□ P
Last Eye Exam	_____	
Glasses	□ N	□ P
Contact	□ N	□ P
Cataracts	□ N	□ P
EARS		
Hard of Hearing	□ N	□ P
Deafness	□ N	□ P
Ringing	□ N	□ P
Discharge	□ N	□ P
Earache	□ N	□ P
Itching	□ N	□ P
Dizziness	□ N	□ P
Room Spins	□ N	□ P
NOSE		
Decreased Smell	□ N	□ P
Bleeding	□ N	□ P
Pain	□ N	□ P
Discharge	□ N	□ P
Obstruction	□ N	□ P
Post Nasal Drip	□ N	□ P
Deviated Septum	□ N	□ P
Runny Nose	□ N	□ P
Sinus Congestion	□ N	□ P
MOUTH		
Bleeding Gums	□ N	□ P
Sores	□ N	□ P
Dental Problems	□ N	□ P
Bad Breath	□ N	□ P
Loss of Taste	□ N	□ P
Dry Mouth	□ N	□ P
Ulcers	□ N	□ P
Blisters	□ N	□ P

THROAT	Now	Past
Soreness	□ N	□ P
Bad Tonsils	□ N	□ P
Hoarseness	□ N	□ P
Pain	□ N	□ P
Trouble Swallowing	□ N	□ P
Recurrent Infections	□ N	□ P
NECK		
Neck Enlargement	□ N	□ P
Stiff Neck	□ N	□ P
Soreness	□ N	□ P
Lumps	□ N	□ P
Masses	□ N	□ P
BREASTS		
Discharge	□ N	□ P
Lumps	□ N	□ P
Pain	□ N	□ P
Bleeding	□ N	□ P
Nipple Changes	□ N	□ P
Skin Changes	□ N	□ P
Bloated	□ N	□ P
LUNGS		
Coughs	□ N	□ P
Phlegm	□ N	□ P
Blood	□ N	□ P
Shortness of Breath	□ N	□ P
Wheezing	□ N	□ P
Pain	□ N	□ P
Congestion	□ N	□ P
Inhalant Exposure	□ N	□ P
HEART		
Murmur	□ N	□ P
Palpitations	□ N	□ P
Rapid Heartbeat	□ N	□ P
Swollen Extremities	□ N	□ P
Cold Extremities	□ N	□ P
Chest Pain/Pressure	□ N	□ P
Varicose Veins	□ N	□ P
Blood Clots	□ N	□ P
Blue Extremities	□ N	□ P
BLOOD		
Anemia	□ N	□ P
Low Blood Iron	□ N	□ P
Easy Bruising	□ N	□ P
Easy Bleeding	□ N	□ P
Swollen Nodes	□ N	□ P
Painful Nodes	□ N	□ P
Sugar in Blood	□ N	□ P
Red Spots	□ N	□ P

Gastrointestinal	Now	Past
Abdominal pain	□ N	□ P
Nausea	□ N	□ P
Bloated	□ N	□ P
Belching	□ N	□ P
Heartburn	□ N	□ P
Indigestion	□ N	□ P
Irregular Bowel Habits	□ N	□ P
Constipation	□ N	□ P
Diarrhea	□ N	□ P
Gas	□ N	□ P
Hemorrhoids	□ N	□ P
Poor appetite	□ N	□ P
Food Intolerance	□ N	□ P
Bloody Stools	□ N	□ P
Black Stools	□ N	□ P
GENITOURINARY		
Urgency	□ N	□ P
Incontinence	□ N	□ P
Straining	□ N	□ P
Back Pain	□ N	□ P
Frequent Voiding	□ N	□ P
Stones	□ N	□ P
Burning	□ N	□ P
Bed Wetting	□ N	□ P
Small Stream	□ N	□ P
Discharge	□ N	□ P
Impotence	□ N	□ P
Dribbling	□ N	□ P
Cloudy Urine	□ N	□ P
Urine Color	_____	
Spotting Between Periods	□ N	□ P
Menstrual Cramps	□ N	□ P
Discharge	□ N	□ P
Itching	□ N	□ P
Painful Intercourse	□ N	□ P
Irregular Periods	□ N	□ P
Hot Flashes	□ N	□ P
Contraception Type	_____	
Age at First Period	_____	
Duration of Cycle	_____	
Duration of Flow	_____	
No. of Pregnancies	_____	
No. of Births	_____	
No. of Miscarriages	_____	
No. of Abortions	_____	
Menstrual Flow	□Heavy □Mod □Light	
Last Period	_____	
Last Pap Smear	_____	
Last Vaginal Exam	_____	
Last Mammogram	_____	
Last Prostate Exam	_____	

Name _____ Date _____

NEURLOGIC	Now	Past
Seizures	□ N	□ P
Vertigo	□ N	□ P
Dizziness	□ N	□ P
Hand Trembling	□ N	□ P
Loss of Sensation	□ N	□ P
In coordination	□ N	□ P
Loss of Facial	□ N	□ P
Weak Grip	□ N	□ P
Paralysis	□ N	□ P
Difficulty Speech	□ N	□ P
Tingling	□ N	□ P
Loss of Memory	□ N	□ P
Numbness	□ N	□ P

ENDOCRINE		
Weight Loss	□ N	□ P
Weight Gain	□ N	□ P
Extremely Thin	□ N	□ P
Heat Intolerance	□ N	□ P
Cold Intolerance	□ N	□ P
Hair Changes	□ N	□ P
Breast Changes	□ N	□ P

IMMUNUZATIONS		
DPT	□ N	□ P
Mumps	□ N	□ P
Smallpox	□ N	□ P
Typhoid	□ N	□ P
Tetanus	□ N	□ P
Measles	□ N	□ P
Pneumococcal	□ N	□ P
Influenza	□ N	□ P
Polio	□ N	□ P
MMR	□ N	□ P

BLOOD TYPE

A+ □ A □-
B+ □ B □-
AB+ □ AB □-
O+ □ O □-
Other _____

BLOOD TRANSFUSION

Date _____

Date _____

Date _____

PSYCHAIATRIC	Now	Past
Hyperventilation	□ N	□ P
Insecurity	□ N	□ P
Depression	□ N	□ P
Troubled Sleep	□ N	□ P
Irritable	□ N	□ P
Undecidedness	□ N	□ P
Timid	□ N	□ P
Hallucinations	□ N	□ P
Loss of Memory	□ N	□ P
Alcoholism	□ N	□ P
Drug Addiction	□ N	□ P
Drug Dependant	□ N	□ P
Suicidal Thoughts	□ N	□ P
Extreme Worry	□ N	□ P
Sexual Problems	□ N	□ P

MUSCULOSKELETAL	Now	Past
Muscle Pain	□ N	□ P
Muscle Weakness	□ N	□ P
Muscle Cramps	□ N	□ P
Muscle Twitching	□ N	□ P
Joint Stiffness	□ N	□ P
Joint Pain	□ N	□ P

PAST MEDICAL HISTORY. Check only the ones that you have had in the past

Hay Fever	□ Y	Parasites	□ Y
Mumps	□ Y	Epilepsy	□ Y
Rheumatic Fever	□ Y	Paralysis	□ Y
Allergies	□ Y	Polio	□ Y
Angina	□ Y	Mental Illness	□ Y
Cancer	□ Y	Alcoholism	□ Y
Tumor	□ Y	Depression	□ Y
Blood Disease	□ Y	Nervous Breakdown	□ Y
Leukemia	□ Y	Migraine	□ Y
Heart Trouble	□ Y	Gout	□ Y
Varicose Veins	□ Y	Hemorrhoids	□ Y
Phlebitis	□ Y	Prostrate Problems	□ Y
Hypertension	□ Y	Sexual Problems	□ Y
Stroke	□ Y	Gonorrhea	□ Y
Ulcers	□ Y	Syphilis	□ Y
Jaundice	□ Y	Diabetes	□ Y
Skin Trouble	□ Y	Bladder Trouble	□ Y
Gallstones	□ Y	Kidney Stones	□ Y
Liver Trouble	□ Y	Kidney Infections	□ Y
Hepatitis	□ Y	Dysentery	□ Y

Date of Last Chest X-Ray _____ □ Normal □ Abnormal

Last TB Skin Test _____ □ Normal □ Abnormal

Allergies_____

_____

_____

Name _____ Date _____

FAMILY HISTORY List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illness
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____

SOCIAL HISTORY Check the boxes and fill in

Current weight _____ Have you recently lost or gained weight? _____

Mental Work □ Heavy □Moderate □Light Hours per day _____

Physical Work □ Heavy □Moderate □Light Hours per day _____

Exercise □ Heavy □Moderate □Light Hours per day _____

Smoking □ Heavy □Moderate □Light Hours per day _____

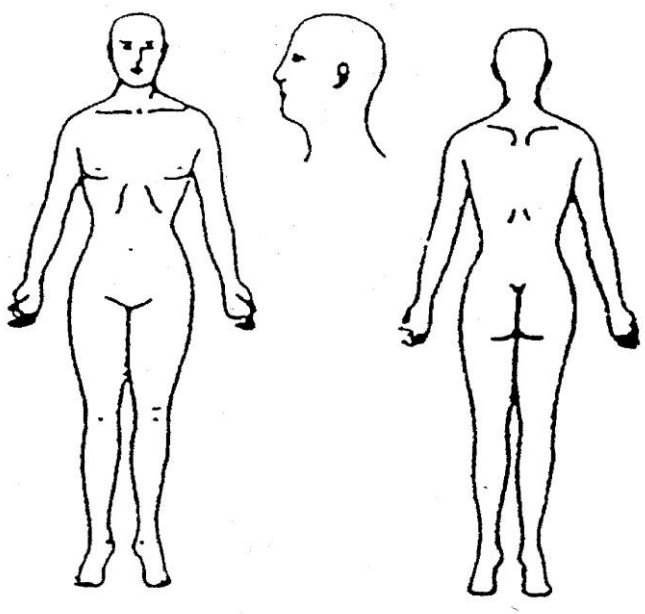
Alcohol Beer/week _____ Liquor/week_____ Wine/week _____ No.of years _____

Caffeine (Coffee, tea, Cola) Cups/day _____ No of Years _____

Aspirin No/Day _____ No of years _____ Other: **TO** _____

MARK THE AREAS OF YOUR SYMTOMS ON THE FIGURE THE RIGHT. Use the following symbols:

Aches^^^^ Numbness OOOO Pins/needles•••• Stabbing///



MARK AN "X" ON THE LINES:
How bad are your symptoms now?

_____

None Most severe

How bad have they been in the past?

_____

None Most severe

Name _____ Date _____