

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

<u>GENERAL</u>	Now	Past	<u>THROAT</u>	Now	Past	<u>Gastrointestinal</u>	Now	Past
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
<u>SKIN</u>			<u>NECK</u>			Irregular Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Masses	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>	<u>BREASTS</u>			Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
<u>HEAD</u>			Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<u>GENITOURINARY</u>		
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Bumps	<input type="checkbox"/>	<input type="checkbox"/>	Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Last Eye Exam	_____	_____	Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>	Straining	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Contact	<input type="checkbox"/>	<input type="checkbox"/>	<u>LUNGS</u>			Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Coughs	<input type="checkbox"/>	<input type="checkbox"/>	Stones	<input type="checkbox"/>	<input type="checkbox"/>
<u>EARS</u>			Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Small Stream	<input type="checkbox"/>	<input type="checkbox"/>
Ringling	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<u>HEART</u>			Urine Color	_____	_____
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Spotting Between	_____	_____
<u>NOSE</u>			Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Periods	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>	Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Contraception Type	_____	_____
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<u>BLOOD</u>			Age at First Period	_____	_____
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Cycle	_____	_____
<u>MOUTH</u>			Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Flow	_____	_____
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	No. of Pregnancies	_____	_____
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	No. of Births	_____	_____
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>	No. of Miscarriages	_____	_____
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>	No. of Abortions	_____	_____
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Sugar in Blood	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Flow	<input type="checkbox"/> Heavy <input type="checkbox"/> Mod <input type="checkbox"/> Light	
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Red Spots	<input type="checkbox"/>	<input type="checkbox"/>	Last Period	_____	_____
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>				Last Pap Smear	_____	_____
Blisters	<input type="checkbox"/>	<input type="checkbox"/>				Last Vaginal Exam	_____	_____
						Last Mammogram	_____	_____
						Last Prostate Exam	_____	_____

Name _____	Date _____
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NEURLOGIC

	<u>Now</u>	<u>Past</u>
Seizures	<input type="checkbox"/> N	<input type="checkbox"/> P
Vertigo	<input type="checkbox"/> N	<input type="checkbox"/> P
Dizziness	<input type="checkbox"/> N	<input type="checkbox"/> P
Hand Trembling	<input type="checkbox"/> N	<input type="checkbox"/> P
Loss of Sensation	<input type="checkbox"/> N	<input type="checkbox"/> P
In coordination	<input type="checkbox"/> N	<input type="checkbox"/> P
Loss of Facial	<input type="checkbox"/> N	<input type="checkbox"/> P
Weak Grip	<input type="checkbox"/> N	<input type="checkbox"/> P
Paralysis	<input type="checkbox"/> N	<input type="checkbox"/> P
Difficulty Speech	<input type="checkbox"/> N	<input type="checkbox"/> P
Tingling	<input type="checkbox"/> N	<input type="checkbox"/> P
Loss of Memory	<input type="checkbox"/> N	<input type="checkbox"/> P
Numbness	<input type="checkbox"/> N	<input type="checkbox"/> P

ENDOCRINE

Weight Loss	<input type="checkbox"/> N	<input type="checkbox"/> P
Weight Gain	<input type="checkbox"/> N	<input type="checkbox"/> P
Extremely Thin	<input type="checkbox"/> N	<input type="checkbox"/> P
Heat Intolerance	<input type="checkbox"/> N	<input type="checkbox"/> P
Cold Intolerance	<input type="checkbox"/> N	<input type="checkbox"/> P
Hair Changes	<input type="checkbox"/> N	<input type="checkbox"/> P
Breast Changes	<input type="checkbox"/> N	<input type="checkbox"/> P

IMMUNUZATIONS

DPT	<input type="checkbox"/> N	<input type="checkbox"/> P
Mumps	<input type="checkbox"/> N	<input type="checkbox"/> P
Smallpox	<input type="checkbox"/> N	<input type="checkbox"/> P
Typhoid	<input type="checkbox"/> N	<input type="checkbox"/> P
Tetanus	<input type="checkbox"/> N	<input type="checkbox"/> P
Measles	<input type="checkbox"/> N	<input type="checkbox"/> P
Pneumococcal	<input type="checkbox"/> N	<input type="checkbox"/> P
Influenza	<input type="checkbox"/> N	<input type="checkbox"/> P
Polio	<input type="checkbox"/> N	<input type="checkbox"/> P
MMR	<input type="checkbox"/> N	<input type="checkbox"/> P

BLOOD TYPE

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

BLOOD TRANSFUSION

Date _____
 Date _____
 Date _____

PSYCHAIATRIC

	<u>Now</u>	<u>Past</u>
Hyperventilation	<input type="checkbox"/> N	<input type="checkbox"/> P
Insecurity	<input type="checkbox"/> N	<input type="checkbox"/> P
Depression	<input type="checkbox"/> N	<input type="checkbox"/> P
Troubled Sleep	<input type="checkbox"/> N	<input type="checkbox"/> P
Irritable	<input type="checkbox"/> N	<input type="checkbox"/> P
Undecidedness	<input type="checkbox"/> N	<input type="checkbox"/> P
Timid	<input type="checkbox"/> N	<input type="checkbox"/> P
Hallucinations	<input type="checkbox"/> N	<input type="checkbox"/> P
Loss of Memory	<input type="checkbox"/> N	<input type="checkbox"/> P
Alcoholism	<input type="checkbox"/> N	<input type="checkbox"/> P
Drug Addiction	<input type="checkbox"/> N	<input type="checkbox"/> P
Drug Dependant	<input type="checkbox"/> N	<input type="checkbox"/> P
Suicidal Thoughts	<input type="checkbox"/> N	<input type="checkbox"/> P
Extreme Worry	<input type="checkbox"/> N	<input type="checkbox"/> P
Sexual Problems	<input type="checkbox"/> N	<input type="checkbox"/> P

MUSCULOSKELETAL

	<u>Now</u>	<u>Past</u>
Muscle Pain	<input type="checkbox"/> N	<input type="checkbox"/> P
Muscle Weakness	<input type="checkbox"/> N	<input type="checkbox"/> P
Muscle Cramps	<input type="checkbox"/> N	<input type="checkbox"/> P
Muscle Twitching	<input type="checkbox"/> N	<input type="checkbox"/> P
Joint Stiffness	<input type="checkbox"/> N	<input type="checkbox"/> P
Joint Pain	<input type="checkbox"/> N	<input type="checkbox"/> P

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

Hay Fever	<input type="checkbox"/> Y	Parasites	<input type="checkbox"/> Y
Mumps	<input type="checkbox"/> Y	Epilepsy	<input type="checkbox"/> Y
Rheumatic Fever	<input type="checkbox"/> Y	Paralysis	<input type="checkbox"/> Y
Allergies	<input type="checkbox"/> Y	Polio	<input type="checkbox"/> Y
Angina	<input type="checkbox"/> Y	Mental Illness	<input type="checkbox"/> Y
Cancer	<input type="checkbox"/> Y	Alcoholism	<input type="checkbox"/> Y
Tumor	<input type="checkbox"/> Y	Depression	<input type="checkbox"/> Y
Blood Disease	<input type="checkbox"/> Y	Nervous Breakdown	<input type="checkbox"/> Y
Leukemia	<input type="checkbox"/> Y	Migraine	<input type="checkbox"/> Y
Heart Trouble	<input type="checkbox"/> Y	Gout	<input type="checkbox"/> Y
Varicose Veins	<input type="checkbox"/> Y	Hemorrhoids	<input type="checkbox"/> Y
Phlebitis	<input type="checkbox"/> Y	Prostrate Problems	<input type="checkbox"/> Y
Hypertension	<input type="checkbox"/> Y	Sexual Problems	<input type="checkbox"/> Y
Stroke	<input type="checkbox"/> Y	Gonorrhea	<input type="checkbox"/> Y
Ulcers	<input type="checkbox"/> Y	Syphilis	<input type="checkbox"/> Y
Jaundice	<input type="checkbox"/> Y	Diabetes	<input type="checkbox"/> Y
Skin Trouble	<input type="checkbox"/> Y	Bladder Trouble	<input type="checkbox"/> Y
Gallstones	<input type="checkbox"/> Y	Kidney Stones	<input type="checkbox"/> Y
Liver Trouble	<input type="checkbox"/> Y	Kidney Infections	<input type="checkbox"/> Y
Hepatitis	<input type="checkbox"/> Y	Dysentery	<input type="checkbox"/> 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 Cups/day _____ No of Years _____
(Coffee, tea, Cola)

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

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

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

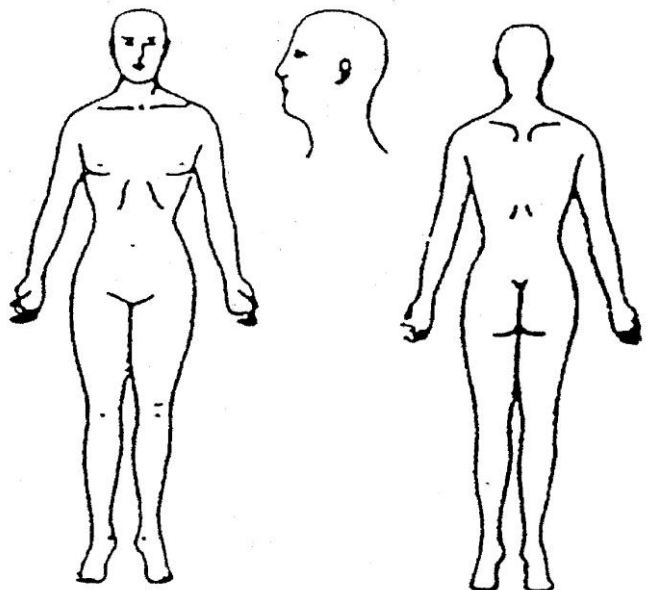
MARK AN "X" ON THE LINES:

How bad are your symptoms now?

None Most severe

How bad have they been in the past?

None Most severe



Name _____ Date _____