

CONFIDENTIAL PATIENT CASE HISTORY

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

Name _____ Case Number _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ Age _____ Sex M F Height _____ Weight _____

S.S. # _____ - _____ - _____ Home # (____) _____ Work # (____) _____ Cell # (____) _____

Marital Status: M S D W No. of Children _____ Spouse's Name _____

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? _____

Which positions make it feel worse? _____

Which 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 _____

What do you think caused this condition? _____

List surgical operations and years: _____

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 _____

REVIEW OF SYSTEMS Check only the ones you now have or have had in the past.

<u>GENERAL</u>	<u>NOW</u>	<u>PAST</u>	<u>MOUTH</u>	<u>NOW</u>	<u>PAST</u>	<u>BLOOD</u>	<u>NOW</u>	<u>PAST</u>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Sores	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>
Parasites	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Sugar in Blood/Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<u>THROAT</u>			Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sleep	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	HIV+/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	<u>GASTROINTESTINAL</u>		
Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>
Small Pox	<input type="checkbox"/>	<input type="checkbox"/>	<u>NECK</u>			Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>
<u>SKIN</u>			Pain	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Masses	<input type="checkbox"/>	<input type="checkbox"/>	Gas/Bloating	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Mole Changes	<input type="checkbox"/>	<input type="checkbox"/>	<u>BREASTS</u>			Poor/Excessive Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
Dry/Brittle	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	<input type="checkbox"/>
<u>HEAD</u>			Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Swollen	<input type="checkbox"/>	<input type="checkbox"/>	Gall Stones	<input type="checkbox"/>	<input type="checkbox"/>
Bumps	<input type="checkbox"/>	<input type="checkbox"/>	<u>LUNGS</u>			Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Last Eye Exam			Cough	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<u>GENITOURINARY</u>		
Contacts	<input type="checkbox"/>	<input type="checkbox"/>	Coughing Up Blood	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
<u>EARS</u>			Short Of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Pain/Excessive Urination	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Straining	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
ringing	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Small Stream	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<u>HEART/CIRCULATION</u>			Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
<u>NOSE</u>			Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Discolored Urine	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Spotting Between Periods	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>
			Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>

NAME _____ DATE _____

GENITOURINARY **NOW** **PAST**

Hot Flashes

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 _____

NEUROLOGIC

Seizures

Vertigo

Dizziness

Hand Trembling

Loss of Sensation

Incoordination

Loss of Facial Control

Weak Grip

Paralysis

Difficulty Speaking

Tingling

Loss of Memory

Numbness

Fainting

Stroke

ENDOCRINE

Weight Loss

Weight Gain

Extremely Thin

Heat Intolerance

Cold Intolerance

Hair Changes

Breast Changes

IMMUNIZATION/VACCINATION

DPT

Mumps

Smallpox

Tetanus

Measles

Pneumococcal

Influenza

Polio

MMR

BLOOD TYPE

A+ B+ AB+ O+

A- B- AB- O-

PSYCHIATRIC **NOW** **PAST**

Hyperventilation

Insecurity

Depression

Troubled Sleep

Irritable

Timid

Hallucinations

Loss of Memory

Alcoholism

Drug Addiction

Drug Dependent

Suicidal Thoughts

Extreme Worry

Sexual Problems

Nervous Breakdown

MUSCULOSKELETAL

Muscle Pain

Fibromyalgia

Muscle Weakness

Muscle Cramps

Joint Stiffness

Joint Pain

Walking Problems

Difficult Chewing/

Clicking Jaw

Low Back Pain

Pain Between Shoulders

Neck Pain

Arm/Wrist Pain

Leg Pain

Arthritis

Date of Last Chest X-Ray _____ Normal Abnormal

Last TB Skin Test _____ Normal Abnormal

Allergies: _____

BLOOD TRANSFUSIONS

Date _____

Date _____

Date _____

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	Illnesses
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 week _____ Type _____

Smoking Current Previous Packs/Day _____ No. of years _____

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 _____ Others _____

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

Aches Numbness oooo Pins/Needles Stabbing ////

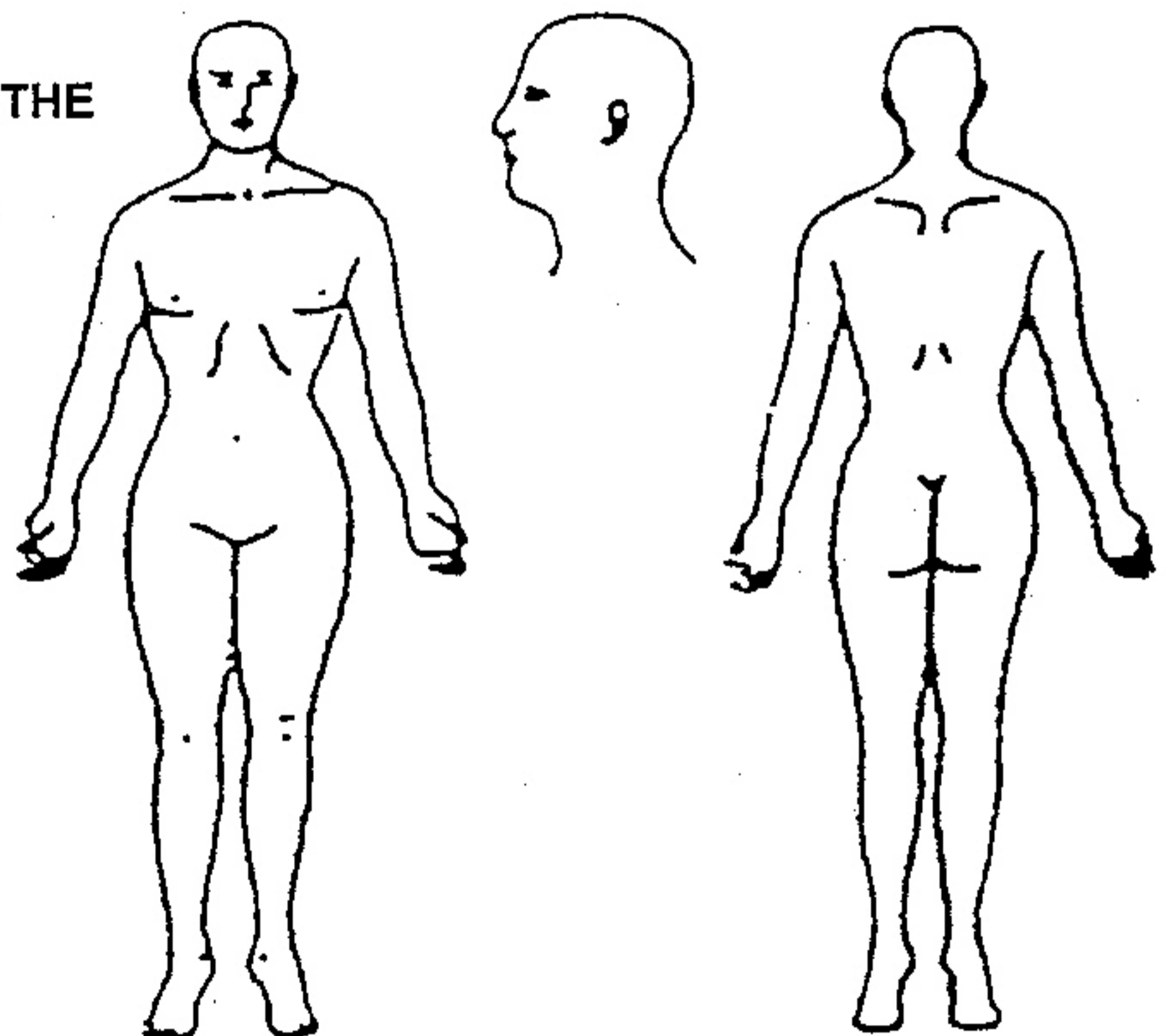
MARK AN "X" ON THE LINES:

How bad are your symptoms now?

_____ None _____ Most Severe

How bad have they been in the past?

_____ None _____ Most Severe



Patient Name _____ Number _____ Date _____ 4