

CONFIDENTIAL PATIENT CASE HISTORY

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

Name _____ Birthday _____ Sex M F

Address _____ City _____ Zip _____

Soc. Sec # _____ Home Phone _____ Work Phone _____

Marital Status: M S D W Children, Ages _____ Email _____

Occupation _____ Employer _____

Spouse's Name _____ Birthday _____ Is Spouse the Insured? Yes No

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

What is your major complaint? _____

When did the condition begin? _____

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: _____

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 _____

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

GENERAL **NOW** **PAST**

Weakness
 Fatigue
 Fever
 Chills
 Night Sweats
 Fainting

SKIN

Color Changes
 Nail Changes
 Hair Changes
 Mole
 Rashes
 Sores
 Weakness

HEAD

Headaches
 Injuries
 Bumps
 Cataracts
 Glasses
 Contacts
 Last Eye Exam _____

EARS

Hard of Hearing
 Deafness
 Ringing
 Discharge
 Earache
 Itching
 Dizziness
 Room Spins
 Decreased Smell
 Bleeding
 Pain
 Discharge
 Obstruction
 Post Nasal Drip
 Deviated Septum
 Runny Nose
 Sinus Congestion

MOUTH

Bleeding Gums
 Sores
 Dental Problems
 Bad Breath
 Loss of Taste
 Dry Mouth
 Ulcers
 Blisters

THROAT **NOW** **PAST**

Soreness
 Bad Tonsils
 Hoarseness
 Pain
 Trouble Swallowing
 Recurrent Infections

NECK

Neck Enlargement
 Stiff Neck
 Soreness
 Lumps
 Masses

BREASTS

Discharge
 Lumps
 Pain
 Bleeding
 Nipple Changes
 Skin Changes
 Bloated

LUNGS

Cough
 Phlegm
 Blood
 Short of Breath
 Wheezing
 Pain
 Congestion
 Inhalant Exposure

HEART

Murmur
 Rapid Heartbeat
 Swollen Extremities
 Cold Extremities
 Chest Pain/Pressure
 Varicose Veins
 Blood Clots
 Blue Extremities

BLOOD

Anemia
 Low Blood Iron
 Easy Bruising
 Easy Bleeding
 Swollen Nodes
 Painful Nodes
 Sugar in Blood
 Red Spots
 High Blood Iron
 Hypoglycemia

GASTROINTESTINAL **NOW** **PAST**

Abdominal Pain
 Nausea
 Bloating
 Belching
 Heartburn
 Indigestion

Irregular Bowel Habits

 Constipation
 Diarrhea
 Gas
 Hemorrhoids
 Poor Appetite
 Food Intolerance
 Bloody Stools
 Black Stools

GENITOURINARY

Urgency
 Incontinence
 Straining
 Back Pain
 Frequent Vomiting
 Stones
 Burning
 Bed Wetting
 Small Stream
 Discharge
 Impotence
 Dribbling
 Cloudy Urine

Urine Color _____
 Spotting Between Periods
 Menstrual Cramps
 Discharge
 Itching
 Painful Intercourse
 Irregular Periods
 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 Vaginal Exam _____
 Last Period _____
 Last Pap Smear _____
 Last Mammogram _____
 Last Prostate Exam _____

NEUROLOGIC **NOW** **PAST**

PSYCHIATRIC **NOW** **PAST**

MUSCULOSKELETAL **NOW** **PAST**

- Seizures
- Vertigo
- Dizziness
- Hand Trembling
- Loss of Sensation
- Incoordination
- Loss of Facial
- Weak Grip
- Paralysis
- Difficulty Speech
- Tingling
- Loss of Memory
- Numbness

- Hyperventilation
- Insecurity
- Depression
- Troubled Sleep
- Irritable
- Undecidedness
- Timid
- Hallucinations
- Loss of Memory
- Alcoholism
- Drug Addiction
- Drug Dependent
- Suicidal Thoughts
- Extreme Worry
- Sexual Problems

- Muscle Pain
- Muscle Weakness
- Muscle Cramps
- Muscle Twitching
- Joint Stiffness
- Joint Pain
- Scoliosis

ENDOCRINE

- Weight Loss
- Weight Gain
- Extremely Thin
- Heat Intolerance
- Cold Intolerance
- Hair Changes
- Breast Changes

IMMUNIZATION/VACCINATION

- DPT
- Mumps
- Smallpox
- Thyroid
- Tetanus
- Measles
- Pneumococcal
- Influenza
- Polio
- MMR

BLOOD TYPE

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

BLOOD TRANSFUSIONS

- Date _____
- Date _____
- Date _____
- Date _____

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

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

Date of Last Spinal X-Ray _____ Normal Abnormal

Date of Last Chest X-Ray _____ Normal Abnormal

Date/Type of Other Diagnostic Tests _____
 Normal Abnormal

Last TB Skin Test _____ Normal Abnormal

Allergies: _____

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 Pack/Day _____ No. of years _____

Alcohol Beer/Week _____ Liquor/Week _____ No. of years _____

Caffeine Cups/Day _____ No. of Years _____
(Coffee, Tea, Cola)

Aspirin No. /Day _____ No. of Years _____ Others _____

MARK YOUR AREAS OF YOUR SYMPTOMS ON THE FIGURE BELOW.

Use the following symbols:

Aches Numbness ○○○○ Pins/Needles +++++ Stabbing ////

MARK AN "X" ON THE LINES:

How bad are your symptoms now?

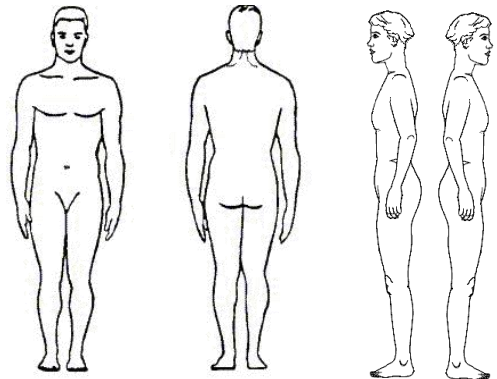
Severity:
Least Pain 1 _____ 10 Most Pain

How bad have they been in the past?

Severity:
Least Pain 1 _____ 10 Most Pain

Frequency:

- Occasional 0-25% Intermittent 26-50%
- Frequent 51-75% Constant 76-100%



NOTES: _____

