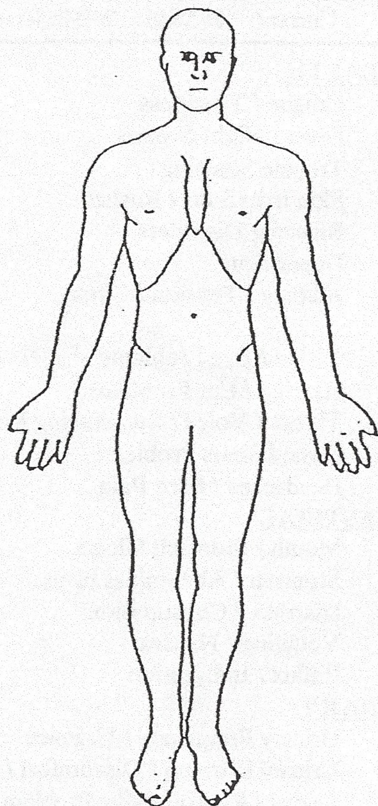
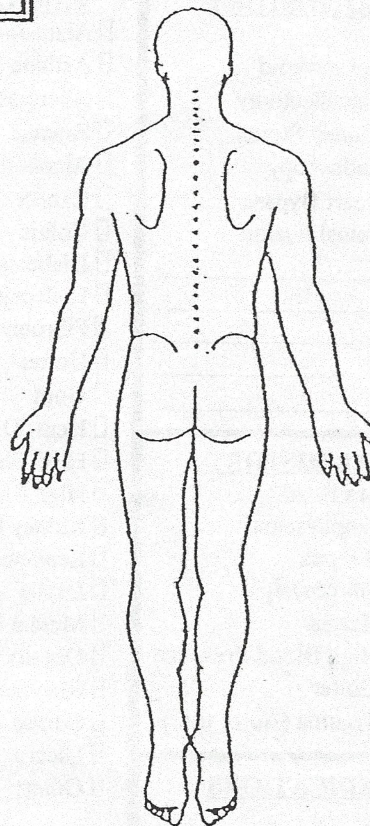
On the diagrams below please mark where you are experiencing your symptoms.

X = PAIN / DISCOMFORT
O = NUMBNESS / TINGLING

Front



Back



PRESENT ILLNESS: ______________________________

____

PAIN:

Initial onset: when ______________________________

how ______________________________

Is it work related? ______________________________

Have you had this problem before now? ______________________________

Have you been treated by another doctor for this same condition? ______________________________

What treatment did you receive? ______________________________

If yes, who have you seen? ______________________________

How many hours per day are you in pain? ______________________________

When is it worse? ______________________________

Does it interrupt you sleep? ______________________________

What makes the pain worse? ______________________________

better? ______________________________

Any weakness? ______________ Numbness? ______________________________

Any change in the bowel or bladder? ______________________________

Patient Signature ______________________________ **Date** ______________

PRINT NAME:________________________ DATE:________________

CHECK OR CIRCLE THE APPROPRIATE RESPONSE - LEAVE BLANK IF IT DOES NOT APPLY

PAST SURGICAL HISTORY

- ▯ Appendectomy ▯ Hemorrhoid
- ▯ Gall Bladder ▯ Tonsillectomy
- ▯ Thyroidectomy ▯ Kidney Stone
- ▯ Bladder ▯ Endoscopy
- ▯ Angioplasty ▯ Heart Bypass
- ▯ Back Surgery ▯ Spinal Fusion
- ▯ Arthroscopic ________
- ▯ Total Joint ________
- ▯ Fracture ________
- ▯ Cancer Biopsy ________
- ▯ Other ________

PAST MEDICAL HISTORY

- ▯ Heart Disease ▯ MVP
- ▯ Asthma ▯ Emphysema
- ▯ Cancer ▯ Anemia
- ▯ Arthritis ▯ Fibromyalgia
- ▯ Stroke ▯ Hernia
- ▯ Allergies ▯ High Blood Pressure
- ▯ Migraines ▯ Goiter
- ▯ Diabetes ▯ Trauma (Auto, etc.)

PRESENT MEDICATIONS

▯ None ▯ List: ________

____

____

ALLERGIES

- ▯ Penicillin ▯ Aspirin
- ▯ Codeine ▯ Sulfa
- ▯ Other: ________

____

____

SOCIAL HISTORY

- ▯ Non-Smoker
- ▯ Smoker (Packs:________)
- ▯ No / Light Caffeine ▯ Heavy Caffeine
- ▯ No Alcohol
- ▯ Alcohol (Drinks:________)

- ▯ No work ▯ Part time
- ▯ Full Time ▯ School
- ▯ Retired ▯ Disability

FAMILY HISTORY

- ▯ Alzheimers
- ▯ Asthma
- ▯ Allergies
- ▯ Anemia
- ▯ Alcoholism
- ▯ Cancer
- ▯ Colitis
- ▯ Diabetes
- ▯ Epilepsy
- ▯ Fibromyalgia
- ▯ Goiter
- ▯ Gout
- ▯ Heart Disease
- ▯ High Blood Pressure
- ▯ High Cholesterol
- ▯ Kidney Disease
- ▯ Leukemia
- ▯ Lupus
- ▯ Mental Conditions
- ▯ Obesity
- ▯ Rheumatoid Arthritis
- ▯ Stroke
- ▯ Ulcers
- ▯ Other: ________

FEMALES ONLY

Pregnant? ▯ YES ▯ NO ▯ UNKNOWN

Last Menstrual Period: ________

- ▯ Endometriosis
- ▯ Hysterectomy / Tubal
- ▯ Breast Implants
- ▯ Breast Biopsy
- ▯ Mastectomy
- ▯ C-Section

MALES ONLY

- ▯ Prostate Problems

REVIEW OF SYSTEMS

P=Past Current: 1=Mild 2=Moderate 3=Severe

GENERAL HEALTH

- P 1 2 3 Fatigue / Tiredness
- P 1 2 3 Fever / Night Sweats
- P 1 2 3 Trouble Sleeping
- P 1 2 3 Skin Irritations / Rashes
- P 1 2 3 Bleeding Disorders
- P 1 2 3 Depression
- P 1 2 3 Anxiety / Tension / Stress

EENT

- P 1 2 3 Vision / Eye Problems
- P 1 2 3 Hearing / Ear Problems
- P 1 2 3 Throat / Voice / Swallowing Problems
- P 1 2 3 Nasal / Sinus Problems
- P 1 2 3 Headaches / Face Pain

GASTROINTESTINAL

- P 1 2 3 Mouth / Stomach Ulcers
- P 1 2 3 Stomach / Abdominal Pains
- P 1 2 3 Diarrhea / Constipation
- P 1 2 3 Vomiting / Nausea
- P 1 2 3 Reflux / Indigestion

GENITOURINARY

- P 1 2 3 Urinary Frequency / Urgency
- P 1 2 3 Urinary Burning / Discomfort / Discoloration
- P 1 2 3 Sexual / Reproductive Problem

CARDIOPULMONARY

- P 1 2 3 Breathing Problems
- P 1 2 3 Swelling / Edema
- P 1 2 3 Chest Pains

SKELETAL

- P 1 2 3 Morning Stiffness
- P 1 2 3 Night Pain
- P 1 2 3 Neck Pain
- P 1 2 3 Back Pain
- P 1 2 3 Joint Pain: ________

NEUROMUSCULAR

- P 1 2 3 Muscle Pain
- P 1 2 3 Muscle weakness
- P 1 2 3 Numbness / Tingling
- P 1 2 3 Tremors / Shakes
- P 1 2 3 Loss of consciousness / Passing out

PATIENT SIGNATURE: ________________

DOCTOR INITIALS ________ DATE ________

08-27-97

-OVER-