Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASE YOU HAVE HAD:

☐ Pneumonia
☐ Rheumatic Fever
☐ Polio
☐ Tuberculosis
☐ Whooping Cough
☐ Anemia
☐ Measles
☐ Mumps
☐ small Pox
☐ Chicken Pox
☐ Diabetes
☐ Cancer
☐ Heart Disease
☐ Thyroid
☐ Influenza
☐ Pleurisy
☐ Arthritis
☐ Epilepsy
☐ Lumbago
☐ Eczema
☐ Mental Disorder
☐ INTAKE
☐ coffee
☐ Tea
☐ Alcohol
☐ Cigarettes
☐ White sugar

Have you been tested for HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

☐ Joint Pain/Stiffness
☐ Walking Problems
☐ Difficult Chewing/Clicking Jaw
☐ General Stiffness

Nervous System Code

☐ Nervous
☐ Numbness
☐ Paralysis
☐ Dizziness

GASTRO-INTESTINAL CODE

☐ Poor/Excessive Appetite
☐ Excessive Thirst
☐ Frequent Nausea
☐ Liver Problems
☐ Gall Bladder Problems
☐ Abdominal Cramps

☐ Forgetfulness
☐ Confusion
☐ Fainting
☐ Convulsions
☐ Cold/Tingling Extremities
☐ Stress

General Code

☐ Allergies
☐ Fever

GENITO-URINARY CODE

☐ Bladder Trouble
☐ Painful/Excessive Urination
☐ Discolored Urine

MALE/FEMALE CODE

☐ Menstrual Irregularity
☐ Menstrual Cramps
☐ Vaginal Pain/Infection
☐ Breast Pain/Lumps
☐ Prostate Problem
☐ SexualDysfunction
☐ Other Problems

C-V-R Code

☐ Chest Pain
☐ Blood Pressure Problems
☐ Heart Problems
☐ Lung Problems/Congestion
☐ Varicose Veins
☐ Ankle Swelling

EENT CODE

☐ Vision Problems
☐ Dental Problems
☐ Sore Throat
☐ Ear Aches
☐ Hearing Difficulty
☐ Stuffed Nose

FAMILY HISTORY

The following members have a same or similar problem as I do:

☐ Mother
☐ Father
☐ Brother
☐ Sister
☐ Spouse
☐ Child

Date	I.D. NO.

Confidential Patient Health Record

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Birth Date: _____ Age: Sex: M F

Cell Phone: _____ E-mail Address: _____

Social Security#: _____ Driver's License Number: _____

Check One: ☐ Married: ☐ Single: ☐ Widowed ☐ Divorced ☐ Separated

Business Employer: _____ Type of Work: _____

Business Phone: _____

Name of Spouse: # of Children:

Referred to This Office by: _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who Is Responsible For Your Bill, You and:

☐ Spouse ☐ Worker's Comp. ☐ Auto Insurance ☐ Medicare ☐ Attorney

☐ Personal Health Insurance (Name):

CURRENT HEALTH CONDITION

Unwanted Health Condition _____

Other Doctors Seen For This Condition: ☐ Yes Who? _____ ☐ No

Is this condition: ☐ Job related ☐ Auto accident ☐ Home injury ☐ Fall ☐ Other:

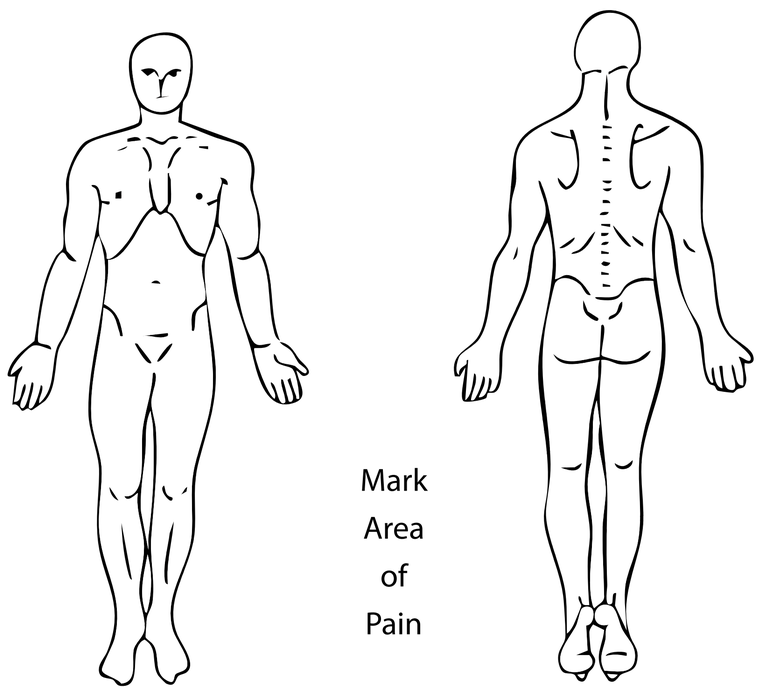
Date of the Accident: _____ Time of accident: _____

Have You Made A Report of Your Accident To Your Employer? ☐ Yes ☐ No

MEDICAL HISTORY

PATIENT NAME: DATE:

IF YOU ARE NOT IN PAIN, please list your current complaints below. IF YOU ARE IN PAIN, mark area of pain on diagram and describe.



Mark Area of Pain

When were you first aware of the problem(s)?							
What caused the problem(s)?	specific incident	multiple incidents	gradual onset	no reason			
Have you received treatment for the problem(s)?	yes	no	If yes, where, when, results?				
Have you previously experienced similar symptoms?	yes	no	If yes, when?				
Were you treated previously for similar symptoms?	yes	no	If yes, where, when, results?				
Has/Have problem(s) been getting/staying	better	worse	same	Comments:			
What makes your problem better?	nothing	lying down	walking	standing	sitting movement	inactivity	food intake
What makes your problem worse?	nothing	lying down	walking	standing	sitting movement	inactivity	food intake
How would you rate your level of stress?	no stress	minimal stress	moderate stress	severe stress			
Describe your physical activities at work:	sit 50+% of time	stand 50+% of time	light labor	heavy labor			
Describe your regular physical activity/exercise:	none	light	moderate	strenuous			
What aspects of your life have been affected?	home life	work life	recreation	rest / sleep			
Describe the affects on your life:							
Do you need assistance with everyday tasks?	yes	no	Comments:				
Do you need assistance often?	yes	no					
Can you function without assistance?	yes	no					
Do you have any physical restrictions?	yes	no					
Are you able to work?	yes	no					
Are you pregnant?							
Any accidents, injuries or illnesses NOT reported above?	yes	no	Date of last menstrual period:				
CURRENT DRUGS and PAST SURGERIES:	need more space-						
Mafor Accidents or Falls , Broken Bones							

HEAD - (CIRCLE AS MANY AS APPLY)

Symptoms: Lightheaded, Fainting, Loss Of Balance, Memory Loss, Double Vision, Blurred Vision, Light Sensitivity, Bloodshot Eyes, Hearing Loss, Ringing In Ears, Head Feels Heavy

HEADACHE: Migraine, Tension, Pressure, Throbbing, Sinus

Frequency: Daily 1XWeek, 2XWeek, 3XWeek, __XWeek, __XMonth

Locations: Back Of Head, Forehead, Temples, Behind Eyes, All Over

My Symptoms Are: Constant, Frequent, Intermittent, Occasional

Pain Scale (0-10): Mild, Moderate, Severe, Dull, Sharp, Burn, Throbbing — Score:

CHEST - (CIRCLE AS MANY AS APPLY)

Pain Between Ribs (Left / Right / Both)

Pain In Breast Bone (Left / Right / Both)

Shortness Of Breath Irregular Heartbeat

My Symptoms Are: Constant, Frequent, Intermittent, Occasional

Pain Scale (0-10): Mild, Moderate, Severe, Dull, Sharp, Burn, Throbbing — Score: _____

NECK - (CIRCLE AS MANY AS APPLY)

Pain / Tension: Pain, Stiff, Tight, Tension, Ache, Left Side, Right Side, Both Sides, Base of Skull, Nape of Neck, Entire Neck, Muscle Spasms, Muscle Weakness, Grinding/Grating

Aggravated by: Forward Movement, Backward Movement, Rotate Left, Rotate Right, Bend Left, Bend Right

My Symptoms Are: Constant, Frequent, Intermittent, Occasional

Pain Scale (0-10): Mild, Moderate, Severe, Dull, Sharp, Burn, Throbbing — Score: _____

ABDOMEN - (CIRCLE AS MANY AS APPLY)

Constipation, Indigestion, Nausea, Diarrhea, Heartburn, Gas, Loss

Of Appetite, Nervous Stomach, Pain

My Symptoms Are: Constant, Frequent, Intermittent, Occasional

Pain Scale (0-10): Mild, Moderate, Severe, Dull, Sharp, Burn, Throbbing — Score: _____

SHOULDERS - (CIRCLE AS MANY AS APPLY)

Pain Across Shoulders (Left / Right / Both)

Pain In Joint (Left / Right / Both)

Limitation Of Motion (Left / Right / Both)

My Symptoms Are: Constant, Frequent, Intermittent, Occasional

Pain Scale (0-10): Mild, Moderate, Severe, Dull, Sharp, Burn, Throbbing — Score: _____

LOW BACK - (CIRCLE AS MANY AS APPLY)

Low Back Pain (Left / Right / Both)

Sacroiliac Pain (Left / Right / Both)

Buttock Pain (Left / Right / Both)

Hip Pain (Left / Right / Both)

My Symptoms Are: Constant, Frequent, Intermittent, Occasional Pain Scale (0-10): Mild, Moderate, Severe, Dull, Sharp, Burn, Throbbing — Score: _____

ARMS & HANDS - (CIRCLE AS MANY AS APPLY)

Pain In:
Upper Arm (Left / Right / Both)
Elbow (Left / Right / Both)
Forearm (Left / Right / Both)
Wrist (Left / Right / Both)
Hand (Left / Right / Both)

Pins & Needles In: Arm (Left / Right / Both), Hand (Left / Right / Both)

Numbness In: Arm (Left / Right / Both), Hand (Left / Right / Both)

My Symptoms Are: Constant, Frequent, Intermittent, Occasional

Pain Scale (0-10): Mild, Moderate, Severe, Dull, Sharp, Burn, Throbbing — Score:

LEGS & FEET - (CIRCLE AS MANY AS APPLY)

Pain Radiates Down Leg to: Mid-Thigh (Left / Right / Both),
Knee (Left / Right / Both),
Calf (Left / Right / Both),
Foot (Left / Right / Both)
Pins & Needles In: Leg (Left / Right / Both),
Foot (Left / Right / Both)
Numbness In: Leg (Left / Right / Both),
Foot (Left / Right / Both)

Ankle Pain, Swollen Ankle, Foot Pain, Swollen Feet, Cramps

My Symptoms Are: Constant, Frequent, Intermittent, Occasional

Pain Scale (0-10): Mild, Moderate, Severe, Dull, Sharp, Burn, Throbbing — Score: _____

MID BACK - (CIRCLE AS MANY AS APPLY)

Pain: Left / Right / Center

Spasms: Left / Right / Center

Tension: Left / Right / Center

My Symptoms Are: Constant, Frequent, Intermittent, Occasional

Pain Scale (0-10): Mild, Moderate, Severe, Dull, Sharp, Burn, Throbbing — Score: _____

OTHER - (CIRCLE AS MANY AS APPLY)

Anxiety, Nervousness, Irritability, Apprehension

Fatigue, Depression, Inability to Concentrate

Hemorrhoids, Ulcers, Cancre Sores

Frequent Urination, Painful Urination, Incontinence

Difficulty Starting Urinary Flow, Difficulty Holding Urine

Recurrent Infections, Prostate Trouble

Menstrual Pain, Hot Flashes, PMS

Frequent Colds, Asthma, Chronic Cough

Weight Loss, Weight Gain, Hypoglycemia, Diabetes

My Symptoms Are: Constant, Frequent, Intermittent, Occasional

Comments: _____

CHECK ANY of the following conditions YOU NOW HAVE

METABOLIC:
[ ] Heart Disease
[ ] Cancer
[ ] Stroke
[ ] Arthritis
[ ] Neuritis
[ ] Colitis

DIGESTIVE:
[ ] Irritable Bowel
[ ] Belching
[ ] Flatulence
[ ] Vomiting
[ ] Blood in Stool
[ ] Food Sensitivities

DIGESTIVE:
[ ] Irritable Bowel
[ ] Belching
[ ] Flatulence
[ ] Vomiting
[ ] Blood in Stool
[ ] Food Sensitivities

OTHER: _____

I understand that the information provided above will assist the doctor in making clinical decisions and acknowledge that these records and any tests performed, will remain a part of my permanent record. I have answered every question fully and completely.

SIGNATURE of PATIENT/GUARDIAN _____