

MEDICAL HISTORY

FOR OFFICE USE ONLY: ACCOUNT # _____

Name: _____ Date: _____

Name of Referring Physician: _____ Age: _____

Name of Family Physician: _____ Height: _____

Place of Employment: _____ Weight: _____

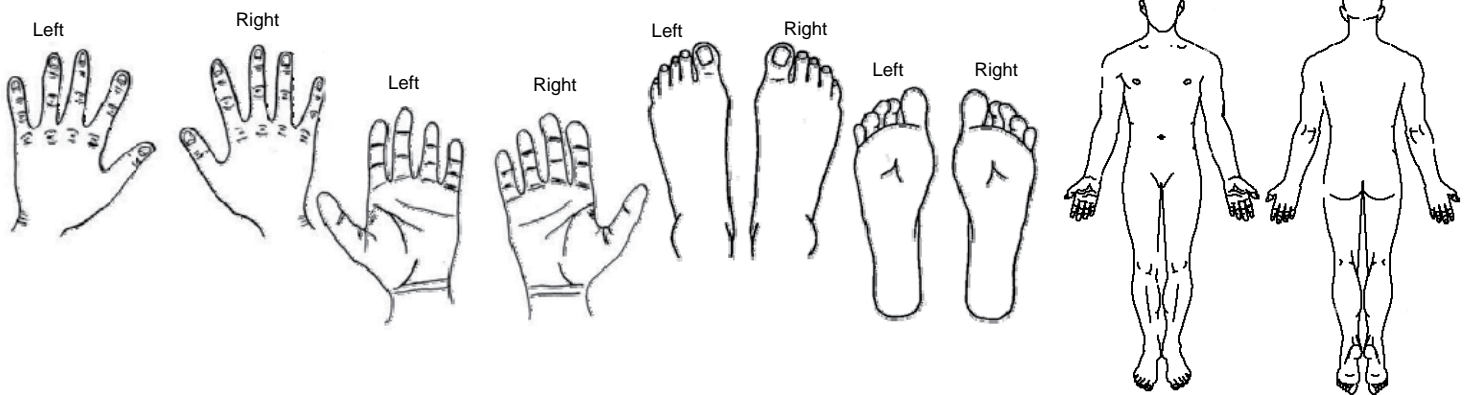
Occupation: _____

Are You Right Handed or Left Handed?

CHIEF COMPLAINT: (brief description of what hurts) _____

HISTORY OF PRESENT ILLNESS: (answer these questions regarding your current problem(s) only)

Where on your body are you having this problem? (may indicate with an "X" on the diagrams below)



What symptoms are you experiencing? _____

How long have you had this problem? _____

Have you had similar pains in the past? Yes No If yes, when? _____

How did it happen? _____

Injury? Yes No If yes, when? _____ Where did it occur? _____

Work related? Yes No If yes, give date of injury: _____ Are you working now? Yes No

Reported to your employer? Yes No How many work days have you missed? _____

Have you had previous work-related injuries? Yes No If yes, when? _____

How severe is this for you? (place an "X" on the line below)

No pain (0) ----- (10) Worst pain of your life

What makes it worse? (e.g. sitting, standing, walking, exercise, coughing/sneezing) _____

What makes it better? (e.g. lying, sitting, standing, walking, exercise, pain pills) _____

What doctors have you seen for this problem? _____

Give previous treatment for this problem: (e.g. emergency room, physical therapy, chiropractic or other alternative treatments) _____

Have you had any of the following diagnostic studies for your current problem?

Diagnostic x-rays Yes No Date: _____

CT (computed tomography) Yes No Date: _____

MRI (Magnetic resonance imaging) Yes No Date: _____

Myelogram Yes No Date: _____

Epidural Steroid / Facet Block injection Yes No Date: _____

EMG (electromyogram) / NCV (nerve conduction study) Yes No Date: _____

Patient's Name: _____ Date of Birth: _____ Date: _____

REVIEW OF SYSTEMS: (indicate yes or no)

Constitutional (overall)

- Fever Yes No
- Weight change Yes No

Eyes

- Visual change Yes No

Ears, Nose, Mouth

- Hearing change Yes No
- Sinus problems Yes No
- Dental problems Yes No

Cardiovascular (heart)

- Chest pain Yes No
- Hypertension Yes No
- Shortness of breath Yes No

Respiratory (breathing)

- Tuberculosis Yes No
- Pneumonia Yes No
- Asthma Yes No

Endocrine (hormones and glands)

- Diabetes Yes No
- Thyroid problem Yes No

Gastrointestinal (digestion)

- Nausea/vomiting Yes No
- Blood in stool Yes No

Genitourinary (urination)

- Urinary infections Yes No
- Incontinence Yes No

Skin

- Infections Yes No
- Lesions/ulcers Yes No

Neurologic (nervous system)

- Seizures Yes No
- Paralysis Yes No

Psychiatric (emotions)

- Depression Yes No

Hematologic (blood)

- Blood clots Yes No
- Bleeding Yes No

Other: _____

PAST MEDICAL HISTORY: (list those medical conditions for which you are followed by your doctor)

- 1. _____ 2. _____
- 3. _____ 4. _____
- 5. _____ 6. _____

PAST SURGICAL HISTORY: (list prior surgeries, especially those related to your current problem)

- 1. _____ 2. _____
- 3. _____ 4. _____

DRUG ALLERGIES: _____

MEDICATIONS: (list name, dose, & frequency) Pharmacy Name: _____ Phone: _____

- 1. _____ 2. _____
- 3. _____ 4. _____
- 5. _____ 6. _____
- 7. _____ 8. _____

FAMILY MEDICAL HISTORY: (list medical illnesses affecting your immediate family)

- 1. _____ 2. _____
- 3. _____ 4. _____

SOCIAL HISTORY: (check all that apply)

- single married widowed divorced
- tobacco use (# packs per day) _____ alcohol use (# drinks per day) _____

ADDITIONAL PATIENT COMMENTS: _____

INTERNAL USE ONLY:

- 1. Reviewed by: _____ Date: _____ 3. Reviewed by: _____ Date: _____
- 2. Reviewed by: _____ Date: _____ 4. Reviewed by: _____ Date: _____