

# History Form

Patient Name: \_\_\_\_\_

Date of Consultation: \_\_\_\_\_

Age: \_\_\_\_\_  Male  Female

Social Security No.: \_\_\_\_\_

## REFERRING PHYSICIAN

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State, Zip: \_\_\_\_\_

Phone No.: \_\_\_\_\_

## FAMILY PHYSICIAN

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State, Zip: \_\_\_\_\_

Phone No.: \_\_\_\_\_

**CHIEF COMPLAINT:** (Explain what brought you into the office today.) \_\_\_\_\_

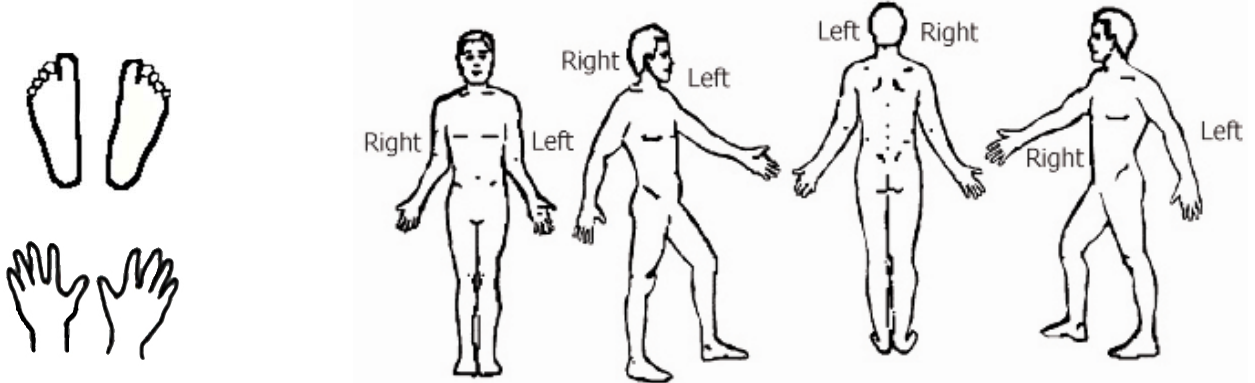
Do you have pain or another symptom? \_\_\_\_\_

A particular condition or diagnosis? \_\_\_\_\_

Did a physician ask you to come to our office for a particular type of treatment? \_\_\_\_\_

## HISTORY OF PRESENT ILLNESS:

Please indicate on the drawings below where your pain is located.



Please circle any of the following symptoms that you are experiencing.

Is your problem: constant, intermittent, frequent, occasional, infrequent

Is the pain: sharp, dull, aching, throbbing, burning, tingling, shooting, stabbing, electrical

Is your problem: mild, moderate, severe, excruciating

How would you rate your average pain on a scale of 0 to 10, where 0 is no pain and 10 is unbearable? \_\_\_\_\_

How long have you been experiencing this problem? \_\_\_\_\_

Do any of the following make the problem worse: time of day, sitting, standing, bending, lifting, twisting, crawling, stair climbing, coughing, sneezing, heat, cold, eating, weather changes, light touch, stress, other, \_\_\_\_\_

Do any of the following make the problem better: rest, heat, cold, massage, medication, other \_\_\_\_\_

Are there any factors or symptoms that occur with your problem, such as, numbness, muscle weakness, bowel or bladder problems, or others? \_\_\_\_\_

What doctors have you seen for this problem? (Name and Specialty) \_\_\_\_\_

What tests have you had for this problem and what were the results, if known?

MRI \_\_\_\_\_

CT Scan \_\_\_\_\_

X-Rays \_\_\_\_\_

EMG \_\_\_\_\_

What treatments have you had for this problem and what were the results?

Surgery \_\_\_\_\_

Physical Therapy/Occupational Therapy \_\_\_\_\_

Injections/Nerve Blocks \_\_\_\_\_

TENS \_\_\_\_\_

Psychological/Behavioral Pain Management \_\_\_\_\_

Osteopathic/Chiropractic Manipulation \_\_\_\_\_

Acupuncture \_\_\_\_\_

What medication are you currently taking for this problem and how much? \_\_\_\_\_

What medication have you used in the past for this problem? \_\_\_\_\_

**PAST MEDICAL HISTORY:** Do you have any of the following conditions? Please check all that apply.

- |                                                      |                                                 |                                                 |
|------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Scleroderma            |
| <input type="checkbox"/> High Cholesterol            | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Carpal Tunnel Syndrome |
| <input type="checkbox"/> Irregular Heart Beat        | <input type="checkbox"/> Pancreatitis           | <input type="checkbox"/> Glaucoma               |
| <input type="checkbox"/> Congestive Heart Failure    | <input type="checkbox"/> Stomach Ulcers         | <input type="checkbox"/> Strokes                |
| <input type="checkbox"/> Coronary Artery Disease     | <input type="checkbox"/> GERD                   | <input type="checkbox"/> TIAs                   |
| <input type="checkbox"/> Heart Attack/MI             | <input type="checkbox"/> Thyroid Disorder       | <input type="checkbox"/> Seizure Disorder       |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Headaches              |
| <input type="checkbox"/> Sleep Apnea                 | <input type="checkbox"/> Gynecological Problems | <input type="checkbox"/> Depression             |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Pregnancy / LMP _____  | <input type="checkbox"/> Anxiety/Panic Disorder |
| <input type="checkbox"/> Bronchitis/Emphysema/COPD   | <input type="checkbox"/> Osteoarthritis         | <input type="checkbox"/> Bleeding Disorder      |
| <input type="checkbox"/> Pneumonia                   | <input type="checkbox"/> Rheumatoid Arthritis   | <input type="checkbox"/> HIV/AIDS               |
| <input type="checkbox"/> Tuberculosis                | <input type="checkbox"/> Lupus                  | <input type="checkbox"/> Cancer, type _____     |
| <input type="checkbox"/> Other, _____                |                                                 |                                                 |

**PAST SURGICAL HISTORY:** (Please list all surgeries you have had and the approximate dates.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HOSPITALIZATIONS:** (If you have been hospitalized, when was it and for what reason.) \_\_\_\_\_

\_\_\_\_\_

**Accidents/Injuries:** (Please list any significant accidents or injuries and when they occurred.) \_\_\_\_\_

\_\_\_\_\_

**Medications:** (Please list all medications you are currently taking, including aspirin.)

1. \_\_\_\_\_ 4. \_\_\_\_\_ 7. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_ 8. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_ 9. \_\_\_\_\_

**Allergies:** Please list all medication and other allergies. \_\_\_\_\_

\_\_\_\_\_

**Family History:** Please list any illnesses that are present in your family or the cause of their death: \_\_\_\_\_

\_\_\_\_\_

### **SOCIAL HISTORY:**

Married     Single     Divorced     Separated     Widow/Widower

Do you live with your spouse or significant other?  Yes     No

How many children and grandchildren do you have? Children \_\_\_\_\_ Grandchildren \_\_\_\_\_

If you smoke, how many packs per day and for how many years? \_\_\_\_\_

How many alcoholic beverages do you drink a day? \_\_\_\_\_

Do you now or have you ever used illegal drugs? \_\_\_\_\_

Have you ever been the victim of abuse or violence? \_\_\_\_\_

What is your highest level of education? \_\_\_\_\_ Do you have vocational training and in what area? \_\_\_\_\_

### **OCCUPATIONAL HISTORY**

Working full-time     Working part-time     On medical leave     Disabled     Unemployed     Retired

What is your current occupation? \_\_\_\_\_

Where do you work and how long have you been there? \_\_\_\_\_

**REVIEW OF SYSTEMS:** Please circle of any of the following symptoms that you are experiencing.

**General:**    Weight gain/loss, Fatigue, Fever, Chills, Night Sweats

**Skin:**    Hair changes, Nail changes, Itching, Rashes

**Head:**    Trauma, Headaches

**Eyes:**    Vision loss, Blurriness, Tearing, Glasses, Contact lenses

**Ears:**    Hearing loss, Ringing, Dizziness, Ear ache

**Nose/Sinuses:**    Allergies, Nose bleed

**Mouth/Throat/Neck:** Bleeding gums, Hoarseness, Sore throat, Difficulty swallowing, Swollen neck, Masses

**Breasts:** Skin changes, Lumps/masses, Discharge

**Respiratory:** Shortness of breath, Wheezing, Productive cough, Coughing up blood

**Cardiovascular:** Palpitations, Heart murmur, Chest pain, Shortness of breath lying down, during sleep, Leg swelling, Leg pain, Leg pain when walking

**GI:** Loss of appetite, Nausea, Vomiting, Indigestion, Irregular bowel movements, Constipation, Diarrhea, Vomiting blood, Bloody stools, Black/tarry stools, Hemorrhoids, Abdominal pain, Jaundice

**Urinary:** Frequency, Urgency, Hesitancy, Painful urination, Blood in urine, Incontinence, Stones, Infections

**Male:** Testicular pain or masses, Hernias, Discharge, STD's, Loss of sex interest/function

**Female:** Pregnant, Irregular periods, Painful periods, Hot flashes/sweats, STD's, Loss of sex interest/function

**Musculoskeletal:** Joint stiffness, Joint instability, Reduced range of motion, Swelling/redness of joints

**Neurological:** Numbness, Tingling, Loss of sensation, Muscle weakness, Paralysis, Tremors, Seizures  
Fainting/blackouts

**Hematologic:** Anemia, Easy bruising/bleeding, Bleeding disorder, Transfusions

**Endocrine:** Heat/cold intolerance, Excessive sweating, Excessive thirst, Excessive Hunger

**Psychiatric:** Changes in mood, Stress/tension, Anxiety, Depression, Thoughts of suicide, Memory problems

**FUNCTIONAL STATUS:**

How long can you: Sit \_\_\_\_\_  
Stand \_\_\_\_\_  
Walk \_\_\_\_\_  
Climb Stairs \_\_\_\_\_  
Drive \_\_\_\_\_

- Does the pain interfere with:
- Daily activities
  - Eating
  - Dressing
  - Bathing
  - Using the toilet
  - Getting out of Bed/Chair
  - Recreational activities
  - Housework
  - Yard work
  - Work Duties

**PATIENT GOALS**

What are your goals for treatment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Thank you for completing this questionnaire. It will help us serve you better.