

**Skim through entire form before starting to fill this out.**

**Please Print**

# CURRENT MEDICAL HISTORY

Long answers may be continued on the back of any sheet.

Patient name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Who referred you: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

Address of family physician: \_\_\_\_\_

\_\_\_\_\_

What are your Major Concern(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are your Other Concerns and when did they start: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When did your major concern(s) begin? (be specific): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **Pain and Problem History:**

What seemed to really start it? If it was an injury, how did it happen? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





List the weather conditions you feel best in: \_\_\_\_\_

List the weather conditions you feel worst in: \_\_\_\_\_

**DIAGNOSTIC TESTING**—Please bring a paper copy of your test reports, and the actual films of plain x-rays if possible.

Lab tests, Blood tests, MRI scan reports, CT scan reports, EMG reports, etc.

Do not copy the test report into this table.

TEST NAME	DATE TEST was DONE	FACILITY where test was DONE	WHAT RESULTS WERE YOU TOLD?

**What SURGERIES have you had?**

SURGERY	DATE	REASON for SURGERY	SUCCESSFUL?

## REVIEW OF SYSTEMS

Please check any symptoms that are bothersome to you NOW.

### General

<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Poor balance	<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Fevers
<input type="checkbox"/> Poor sleeping	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Sweat easily	<input type="checkbox"/> Chills
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Strong thirst	<input type="checkbox"/> Localized weakness	<input type="checkbox"/> Tremors	<input type="checkbox"/> Night sweats
<input type="checkbox"/> <b>Cravings for:</b>	<input type="checkbox"/> Sweets	<input type="checkbox"/> Fats	<input type="checkbox"/> Salty food	<input type="checkbox"/> Other _____

### Skin & Hair

<input type="checkbox"/> Rashes	<input type="checkbox"/> Loss of Hair	<input type="checkbox"/> Pimples	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Recent moles	<input type="checkbox"/> Excema	<input type="checkbox"/> Hives
<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Itching	<input type="checkbox"/> Change in hair	<input type="checkbox"/> Change in skin	<input type="checkbox"/> Herpes	<input type="checkbox"/> Other _____	_____

### Cardiovascular

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Chest pains	<input type="checkbox"/> Irregular heartbeat
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Fainting	<input type="checkbox"/> Cold hands	<input type="checkbox"/> Cold feet
<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Blood clots	<input type="checkbox"/> Swelling hands	<input type="checkbox"/> Swelling feet
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Previous heart attack	<input type="checkbox"/> Other _____	_____

### Head, Eyes, Ears, Nose & Throat

<input type="checkbox"/> Concussions	<input type="checkbox"/> Jaw clicking (TMJ) L or R	<input type="checkbox"/> Tooth problems	<input type="checkbox"/> # of teeth pulled
Silver fillings? Yes or No	<input type="checkbox"/> # of silver fillings	Root canals? Yes or No	<input type="checkbox"/> # of root canals
<input type="checkbox"/> Eye pain L or R	<input type="checkbox"/> Poor vision	<input type="checkbox"/> Trouble with night vision	<input type="checkbox"/> Spots in front of eyes
<input type="checkbox"/> Migraine headache	<input type="checkbox"/> Other kind of headache	What kind(s)? _____	<input type="checkbox"/> Mouth sores
<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Facial pain	<input type="checkbox"/> Trouble with taste	<input type="checkbox"/> Trouble with smell
<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Glasses	Other _____

### Immunology

Rheumatoid disease? Yes No	What kind? _____	Diabetes? Yes No	Thyroid problems? Yes No
Cancer? Yes No	What kind? _____	Hepatitis? Yes No	Adrenal problem? Yes No
Breast implants? Yes No	What kind? _____	What kind of hepatitis?	_____
Cancer? Yes No	What kind? _____	Other communicable disease?	_____
Lyme disease? Yes No	Tested for lyme? Yes No	HIV? Yes No	Test positive? or Disease?

### Respiratory

__ Cough	__ Shortness of breath	__ Short of breath with minimal exercise	__ Pneumonia
__ Pain with deep breath	__ Coughing blood	__ Difficulty breathing when lying down	__ Asthma
__ Bronchitis	__ Other _____		

### Gastrointestinal

__ Nausea	__ Abdominal pain/cramping	__ Indigestion	__ Hemorrhoids	__ Vomiting
__ Constipation	__ Number BM's per day or per week	__ Diarrhea	__ Black stools	__ Belching
__ Gas	__ Rectal pain	__ Blood in stools	__ Bad breath	__ Heartburn
__ Pancreatitis	__ Other _____			

### Genitourinary

__ Pain with urination	__ Frequent urination	__ Blood in urine	__ Urgency to urinate
__ Unable to hold urine	__ Kidney stone(s)	How many attacks? _____	__ Decrease in flow
__ Problem with sexual function	__ Impotency	__ Loss of libido (desire)	__ Wake up to urinate
__ Pain with intercourse	__ Sexual disease exposure	__ Sexually transmitted disease	__ Other _____

### Pregnancy and Gynecology

Pregnant? Yes No	Planning to get pregnant? Y N	__ Post menopausal	__ Menopause symptoms
First date of last menses _____	Unusual character? heavy/light	Hot flashes? Y N	Fibrocystic breast Y N
__ Clots	__ Painful periods	__ Irregular periods	__ Vaginal discharge
__ Vaginal sores	__ Breast lumps	__ Birth control	
Number of children _____	# of C-section deliveries: _____	# of vaginal deliveries _____	# of abortions: _____
Ages of children: _____	_____	Type of birth control: _____	_____

### Musculoskeletal

__ Muscle pain	__ Muscle weakness	__ Jaw pain	__ Face pain	__ Neck pain
__ Shoulder pain	__ Elbow pain	__ Arm pain	__ Wrist pain	__ Hand pain
__ Finger pain	__ Upper back pain	__ Lower back pain	__ Hip pain	__ Thigh pain
__ Knee pain	__ Leg pain	__ Ankle pain	__ Foot pain	__ Toe pain
__ Osteoporosis	__ Scoliosis	__ Other: _____	_____	__ Chest pain



## Additional History

Childhood illnesses: \_\_\_\_\_

Childhood accidents and any lasting effects: \_\_\_\_\_

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## Current medications

Current medications	Who prescribed them	What are they for?	Are they helpful?

## Pharmacy

Current pharmacy: \_\_\_\_\_

Address or location: \_\_\_\_\_

Phone: \_\_\_\_\_

**Allergies to medication and environment:**

Medication allergies—list medicine and reaction:

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Environmental allergies—list agent and reaction:

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History of allergy testing and treatment:

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Have you ever smoked Tobacco? Y N. How many packs per day? \_\_\_\_\_

How many years a smoker? \_\_\_\_\_ How many times did you quit? \_\_\_\_\_ When? \_\_\_\_\_

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**Do you have a history of alcohol or drug abuse? Treatment for abuse? Please explain:** \_\_\_\_\_

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**Diet:**

red meat — number of meals per week: \_\_\_\_\_

milk — number of glasses per week \_\_\_\_\_ or per day: \_\_\_\_\_ what kind? \_\_\_\_\_

cheese — number of times per week \_\_\_\_\_ or per day \_\_\_\_\_

coffee or tea — number of cups per week \_\_\_\_\_ or per day \_\_\_\_\_.

soda — number of cans per week \_\_\_\_\_ or per day \_\_\_\_\_,

what kind usually? \_\_\_\_\_

other sugar — what sweets do you usually eat and how much? \_\_\_\_\_

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bread — what kind and how much? \_\_\_\_\_

which do you use: margarine or butter? \_\_\_\_\_

what cooking oils do you use? \_\_\_\_\_

what are your favorite foods? \_\_\_\_\_

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**Vitamins: what do you take, and why (only list why for unusual supplements or**

**herbs)?** \_\_\_\_\_

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Sleep: how well do you sleep? \_\_\_\_\_

If not well, why not? \_\_\_\_\_

\_\_\_\_\_

What position do you sleep in? \_\_\_\_\_

\_\_\_\_\_

Do you use a pillow? what kind? where placed? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have stomach sensitivity to aspirin? \_\_\_\_Y \_\_\_\_N

Do you have irritable bowel? \_\_\_\_\_ for how long? \_\_\_\_\_

What are your symptoms? \_\_\_\_\_

\_\_\_\_\_

How is this treated? \_\_\_\_\_

\_\_\_\_\_

Who is the treating doctor? \_\_\_\_\_

Do you have a history of ulcer or indigestion? \_\_\_\_Y \_\_\_\_N please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How is this treated and who is the doctor? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When was your last complete physical examination? \_\_\_\_\_

for what reason? \_\_\_\_\_

What is your occupation: \_\_\_\_\_

If you are disabled, when did you last work? \_\_\_\_\_

What is your disability caused by? \_\_\_\_\_

Anything else you would like us to know? \_\_\_\_\_

What are your goals for this treatment? What do you expect to be able to change?  
with regard to your pain and your life? If you are not working, do you plan to return to work, and how soon?  
How hard are you willing to work to reach your goals?

*To the best of my knowledge, this is complete and accurate.*

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_