

Personal Medical History: Do you have or have you had any of the following:

- High blood pressure Diabetes High cholesterol Stroke
- Heart attack Heart failure Abnormal heart rhythm
- Thyroid disorder Cancer (Specify: _____)
- Blood clots in the legs or lungs Asthma Emphysema COPD
- Depression Other psychiatric problem: (_____)
- Alcohol or substance abuse:(_____)
- Other: (_____)

Females:

How old were you when you started having periods: _____
 Are your periods regular: Yes No (If no, please describe: _____)
 How long do your periods last: _____
 How long do you go between periods: _____
 How old were you when you stopped having periods: _____
 How many times have you been pregnant: _____
 Have you ever had any abnormal PAP smears: No Yes (If yes, please expand: _____)
 How many babies have you delivered: _____ How many pregnancies have you lost: _____

Medications: Please list the medications that you are currently taking, including over-the-counter medicines.

<u>Medication</u>	<u>Dose</u>	<u>How often do you take it</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Continue on reverse if needed.)

- Allergies:** Seafood/Shellfish "Hay fever" Dust Pollen Grass
 Cats Dogs Other: (please specify: _____)

Please list any medications that you are allergic to and what the reaction is that you have to them.



Patient's Name & DOB: _____ Date: _____

Please list any medications that you are allergic to and what the reaction is that you have to them.

<u>Medication</u>	<u>Reaction</u>
_____	_____
_____	_____
_____	_____
_____	_____

Surgical History: Please check the boxes if you have family members who have or have had the following:

<u>Operation</u>	<u>Date</u>	<u>Hospital</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History: Please check the boxes if you have family members who have or have had the following:

(Indicate in the space what family member it is/was using M= Mother, F= Father, B= Brother, S= Sister, PGF= Paternal Grandfather, MGM= Maternal Grandmother, MA= Maternal Aunt, PU= Paternal Uncle etc.)

- High blood pressure _____ Diabetes _____
- High cholesterol _____ Stroke _____
- Heart attack _____ Heart failure _____
- Abnormal heart rhythm _____ Thyroid disorder _____
- Cancer (specify: _____)
- Blood clots in the legs or lungs _____ Asthma _____
- Emphysema _____ COPD _____
- Other _____

Social History:

What is your occupation: _____

Are you Married Single Divorced

Please list your family members below from oldest to youngest (continue on reverse if needed):

Spouse / Significant Other: (name) _____ (age) _____

Son / Daughter : (name) _____ (age) _____

Son / Daughter : (name) _____ (age) _____

Son / Daughter : (name) _____ (age) _____

Son / Daughter : (name) _____ (age) _____

Do you live alone with family (please circle the family members you live with or list them below)

Do you use or have you used tobacco No Yes Quit Year _____

cigarettes cigars smokeless pipe

Patient's Name & DOB: _____ Date: _____

How many cigarettes do you smoke per day: _____

How long have you smoked / did you smoke: _____

How much smokeless tobacco do/did you use: _____

How long have you used / did you use smokeless tobacco: _____

Do you drink alcoholic beverages No Yes (How many drinks per week _____)

Do you use or have you used "street drugs": _____

Review of Systems: Please indicate if you have any of the following by checking the boxes (☒). Boxes left empty are assumed to reflect an answer of "No, I do not have this."

Constitutional: Fevers Drenching night sweats Chills Swollen glands

Cardiovascular: Abnormal heart beat/palpitations Chest pain
 Difficulty breathing Swelling in the arms or legs

Heme: Easy bruising Prolonged bleeding

Respiratory: Shortness of breath Difficulty breathing Easily winded
 Cough Wheezing

GI: Constipation Diarrhea Blood in your stool Heart burn
 Difficulty swallowing Incontinence of stool

Urinary: Pain on urination Blood in your urine Abnormal urine stream
 Incontinence of Urine

Neurologic: Headaches Dizziness Numbness or tingling
 Difficulty with memory or thought processes

Vision: Blurred vision Double vision Loss of vision Glasses/contacts

ENT: Chronic runny nose Chronic nasal congestion Itchy / watery eyes
 Recurrent sinus headaches or infections

Musculoskeletal: Back pain Neck Pain
 Joint pain (specify: _____)
 Other pain: _____

Reproductive: Pain with intercourse Inability to get / maintain an erection
 Difficulty getting pregnant Other: _____

Skin: Rash Moles or pigmented spots that have changed New skin lesions

Patient's Name & DOB: _____ Date: _____

Briefly describe your injury, pain, or the reason for your visit. (Continue on reverse if needed.)

PAIN DIAGRAM

Draw the location of your pain on the body outlines below.

