Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Patient History

Please answer every question.

STAFF: Responses in boxes and handwritten items must be entered **MANUALLY**.

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH (Month / Day / Year)

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

What is your height?

Feet: 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

Inches: 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11 ○

What is the reason for today's visit? _____

Is your visit related to an accident / injury? yes ○ no ○

If yes, where did the accident / injury occur? work ○ auto ○ other ○

Date of onset: _____

How long have you experienced the problem that has brought you to our office? weeks ○ months ○ years ○ *# of:*_____ *# of:*_____ *# of:*_____

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Current severity of symptom(s) on a scale of 0 – 10 *(0 = least painful 10 = most painful)*

☺ No Pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ☹ Most Painful

MEDICATIONS

Please list all medications you are currently taking.
Include prescriptions (pills, inhalers, creams, shots), over the counter medications (aspirin, antacids, etc.), vitamins and supplements (fish oil, etc). Include medications that you use only as needed.

Name of Medication	Dosage	Frequency

Name of Medication	Dosage	Frequency

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Pharmacy name, address and phone number: _____

Are you currently taking any diet pills or have taken them in the past? yes ○ no ○

Have you taken any type of blood thinners *(Baby Aspirin, Coumadin, Plavix, Pradaxa, Vitamin E, etc.)*? yes ○ no ○

Drug name: _____ **How long?** _____ **Date stopped:** _____

ALLERGIES

Please indicate if you have allergies to any of the following.

I HAVE NO KNOWN ALLERGIES ○
Contrast Dye ○
Penicillin ○
Sulfa ○
Iodine ○
Antibiotics ○
Metals ○
Aspirin ○
Shellfish ○
Latex ○
Tape ○

○ **OTHER** *(please specify)*: _____

Race: American Indian or Alaska Native ○ Asian ○ Black or African American ○ Native Hawaiian or Other Pacific Islander ○ White ○

Ethnicity: Hispanic or Latino ○ Not Hispanic or Latino ○

Preferred language: English ○ French ○ Japanese ○ Korean ○ Italian ○ Spanish ○ Other ○

Patient name: _____

Patient History

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PREVIOUS TREATMENTS AND TESTS

Have you had any of the following treatments or tests for this problem? *If other, please describe:*

X-ray(s) ◯ CT Scan ◯ EMG ◯ Physical Therapy ◯ _____

MRI ◯ Ultrasound ◯ Injection(s) ◯ **OTHER** ◯ _____

Where and when did you have the above test(s) or treatment(s)?

_____

Have you had surgery related to today's visit? yes ◯ no ◯

If yes, date and type of surgery: _____

For your current condition, have you tried the following?

Physical Therapy	yes ◯	no ◯	*How long?* _____
Brace	yes ◯	no ◯	*How long?* _____
Cervical Traction	yes ◯	no ◯	*How long?* _____
Splint	yes ◯	no ◯	*How long?* _____
Epidural Blocks	yes ◯	no ◯	*How long?* _____
Bed Rest	yes ◯	no ◯	*How long?* _____

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List all doctors that you currently see:

_____

SOCIAL HISTORY

What is your occupation? _____

What is your marital status? single ◯ domestically partnered ◯ divorced ◯ married ◯ separated ◯ widowed ◯

Please describe your cigarette smoking status. currently (every day) ◯ in the past ◯ current status unknown ◯ currently (some days) ◯ never ◯ unknown if ever smoked ◯

How many packs per day? *(now or in the past)* ½ ◯ 1 ◯ 1½ ◯ 2 ◯ >2 ◯

Counseled to quit smoking? yes ◯ no ◯

Do you drink alcohol? yes ◯ no ◯ in the past ◯

If yes, how many drinks per week? occasionally ◯ 1-3 ◯ 4-7 ◯ 8-14 ◯ >14 ◯

How often do you exercise? never ◯ rarely ◯ 1-3 times / wk ◯ 4-5 times / wk ◯ daily ◯

YOUR MEDICAL HISTORY

Please indicate if YOU have a history of the following. Mark all that apply.

◯ Eye / Vision Problems
◯ Glaucoma
◯ High Blood Pressure
◯ Kidney Problems
◯ Bladder Problems
◯ Prostate Disease
◯ Blood Clots
◯ Phlebitis
◯ Lupus / SLE

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◯ Heart Disease
◯ Heart Attack
◯ Congestive Heart Failure
◯ Sleep Apnea
◯ C-PAP
◯ Asthma
◯ COPD
◯ Lung / Respiratory Disease
◯ Tuberculosis (TB)
◯ Reflux Esophagitis
◯ Liver Disease
◯ Hepatitis
◯ Stomach Ulcers
◯ Dialysis
◯ Osteoporosis
◯ Arthritis
◯ Fibromyalgia
◯ Head Injury
◯ Multiple Sclerosis
◯ Stroke
◯ Seizure / Convulsions
◯ Disc Disease
◯ Diabetes
◯ Thyroid Disease
◯ Anemia
◯ Bleeding Problems
◯ Immune System Disorder
◯ Crohn's Disease
◯ HIV / AIDS
◯ Alcohol Abuse
◯ Diet Pills
◯ Breast Cancer
◯ Cancer
◯ MRSA (Staph Infection)
◯ Motor Vehicle Accident(s)
◯ **OTHER** *(please specify)*: _____
◯ **NONE**

Patient name: _____

Patient History

Please answer every question.

STAFF: Responses in boxes and handwritten items must be entered **MANUALLY**.

FAMILY MEDICAL HISTORY

Does any FAMILY MEMBER of yours have a history of any of the following?
(Include only parents, grandparents, siblings and children.)

- ◯ **Family History Unknown / Adopted**
- ◯ Aneurysm(s)
- ◯ Back or Neck Problems
- ◯ Bleeding Disorders
- ◯ Brain Cancer
- ◯ Migraines
- ◯ Multiple Sclerosis
- ◯ Stroke
- ◯ Surgical Complications
- ◯ NONE

REVIEW OF SYMPTOMS

Please mark all of the following symptoms that have brought you to our office today.
Mark all that apply. If you have no symptoms in a category, please mark "NONE."

GENERAL		fever ◯	weight gain ◯	
	fatigue ◯	persistent infections ◯	weight loss ◯	NONE ◯
EYES		visual disturbances ◯	glasses / contacts ◯	NONE ◯
EAR, NOSE, AND THROAT		hearing loss ◯	oral ulcers ◯	
		seasonal allergies ◯	sinus pain ◯	NONE ◯

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CARDIOVASCULAR		chest pain ◯	palpitations ◯	
		difficulty breathing on exertions ◯	shortness of breath ◯	NONE ◯
RESPIRATORY			difficulty breathing ◯	
		chronic cough ◯	wheezing ◯	NONE ◯
GASTROINTESTINAL		abdominal pain ◯	reflux ◯	
		nausea ◯	vomiting ◯	NONE ◯
	Are you experiencing any bowel changes regarding your visit today?		yes ◯	no ◯
GENITOURINARY	**Are you experiencing any bladder changes regarding your visit today?**		yes ◯	no ◯
MUSCULOSKELETAL		neck pain ◯	loss of strength ◯	
		back pain ◯	joint swelling ◯	NONE ◯
NEUROLOGIC		numbness ◯	tingling ◯	
	headaches ◯	radiating pain in extremity ◯	weakness ◯	NONE ◯
SKIN	dry skin ◯	rash ◯	skin ulcer ◯	NONE ◯
HEME / LYMPHATIC		easy bruising ◯	excessive bleeding ◯	NONE ◯

SURGICAL HISTORY

Please mark all surgeries you have had.
If you have had no surgeries, mark "I HAVE HAD NO SURGERIES".

- ◯ **I HAVE HAD NO SURGERIES**
- ◯ Brain Surgery
- ◯ VP Shunt
- ◯ Thyroid Surgery
- ◯ Lung Surgery
- ◯ Appendectomy
- ◯ Colon Surgery

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- ◯ Neck Surgery
- ◯ Carpal Tunnel Surgery
- ◯ Ulnar Nerve Surgery
- ◯ Pain Pump
- ◯ Spinal Cord Stimulator
- ◯ Back Surgery
- **Spinal Fusion**
  - ◯ Neck ◯ Back
- ◯ Breast Surgery
- ◯ Carotid Artery Surgery
- **Heart Surgery**
  - ◯ Bypass ◯ Cardiac Stent
  - ◯ Valve Replacement
- ◯ Hernia Surgery
- ◯ Gallbladder Surgery
- ◯ Splenectomy
- ◯ Kidney Surgery
- ◯ Hysterectomy
- ◯ Rotator Cuff Surgery
- ◯ Hip Surgery
- ◯ Knee Surgery
- ◯ Foot Surgery
- ◯ **OTHER SURGERY** *(please specify)*: _____

Please indicate if you have any implants in your body. If you have no implants, mark "I HAVE NO IMPLANTS".

- ◯ **I HAVE HAD NO IMPLANTS**
- ◯ Cochlear Implant
- ◯ Defibrillator
- ◯ Pacemaker
- ◯ Stent
- ◯ Vascular Graft
- ◯ Metal Implant(s)
- ◯ **OTHER** *(please specify)*: _____

Signature: _____ **Date:** _____