

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

Date Of Service: \_\_\_\_\_

Other Symptoms	YES	NO	Explanation
<b>Systemic:</b> Fever, chills, fatigue, night sweats, weight loss			
<b>Head:</b> headache, recent head trauma			
<b>Neck:</b> stiffness, swollen glands			
<b>Eyes:</b> eye injury, vision loss, photophobia, ocular pain, double vision blurry vision			
<b>Otolaryngeal:</b> ear pain or discharge, ringing, impaired hearing, vertigo, chronic sinus issues, nosebleeds, loss of smell, post nasal drip, throat soreness, hoarseness, change in voice, gum bleeding, difficulty swallowing			
<b>Breast:</b> Lumps, discharge			
<b>Cardiovascular:</b> chest pain, irregular heartbeat, palpitations, leg swelling, syncope, shortness of breath			
<b>Pulmonary:</b> Cough, dyspnea, hemoptysis wheezing			
<b>Gastrointestinal:</b> abdominal pain, change in appetite, constipation, diarrhea, heartburn, nausea, vomiting, rectal bleed			
<b>Genitourinary:</b> incontinence, frequent urination, burning or painful urination blood in urine			
<b>Endocrine:</b> Thyroid disease, increased thirst or uncontrolled hunger			
<b>Hematologic:</b> anemia, easy bruising or bleeding			
<b>Musculoskeletal:</b> back or neck pain, weakness in extremities, body aches, calf tenderness, joint swelling and pain			
<b>Neurological:</b> loss of consciousness, seizures, focal weakness/ paralysis, gait disturbance, headache, memory impairment, numbness/ tingling, speech disturbances, tremors/shaking			
<b>Psychological:</b> Anxiety, depression, insomnia, psychiatric symptoms			
<b>Skin:</b> Rashes, hives, changes in color or texture of skin			

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

Living Situation "Lives with": \_\_\_\_\_

Age: \_\_\_\_\_

Current Occupation / Prior Occupation (If retired or disabled): \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

2<sup>nd</sup> treating physician: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

3<sup>rd</sup> treating physician: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

# MEDICAL AND HEALTH CARE INFORMATION

PATIENT NAME: \_\_\_\_\_

DRUG ALLERGIES: 1) \_\_\_\_\_ 2) \_\_\_\_\_

3) \_\_\_\_\_ 4) \_\_\_\_\_

CURRENT STATUS: Right Handed \_\_\_\_\_ Left Handed \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Coffee/Tea (cups/day) \_\_\_\_\_ Alcohol (quantity/day) \_\_\_\_\_

Tobacco (packs/day) \_\_\_\_\_ Other Tobacco (quantity/day) \_\_\_\_\_

Recreational Drug Use (Marijuana, cocaine, etc.) \_\_\_\_\_

## CURRENT MEDICATIONS:

PRESCRIPTION NAME	DOSE	FREQUENCY

NON-PRESCRIPTION NAME	DOSE	FREQUENCY

## ACCIDENTS OR INJURIES:

Description: \_\_\_\_\_  
\_\_\_\_\_

Related to: Work    Car Accident    Motorcycle    Other \_\_\_\_\_

Date of Accident \_\_\_\_\_ Disabled from \_\_\_\_\_ thru \_\_\_\_\_

CURRENT SYMPTOMS OR COMPLAINTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# MEDICAL AND HEALTH CARE INFORMATION

PATIENT NAME: \_\_\_\_\_

PAST MEDICAL HISTORY: Please check those that apply.

Aids _____	Drug Addiction _____	Kidney Disease _____
Alcoholism _____	Emotional Problems _____	Pneumonia _____
Anemia _____	Epilepsy _____	Rheumatic Fever _____
Asthma _____	Gall Bladder _____	Stomach/Ulcers _____
Back/Neck Injuries _____	Headaches/Migraine _____	Stroke _____
Bleeding Tendency _____	Heart Disease _____	Thyroid Disease _____
Cancer _____	High Blood Pressure _____	Tuberculosis _____
Diabetes _____	HIV Infection _____	Other(pls. explain) _____

FAMILY HISTORY: Please check those that apply.

Tuberculosis _____	High Blood Pressure _____	Anemia _____
Rheumatic Fever _____	Mental Disease _____	Stroke _____
Stomach Problems _____	Diabetes _____	Arthritis _____
Lung Disease _____	Thyroid Disease _____	Glaucoma _____
Kidney Disease _____	Heart Disease _____	Cancer _____
Bleeding Tendency _____	Other: _____	

	ILLNESSES	If Deceased-At What Age
MOTHER		
FATHER		
SIBLINGS		
SPOUSE		
CHILDREN		

PREVIOUS SURGERIES/HOSPITALIZATIONS/TESTS:

DATE	HOSPITAL/FACILITY	REASON

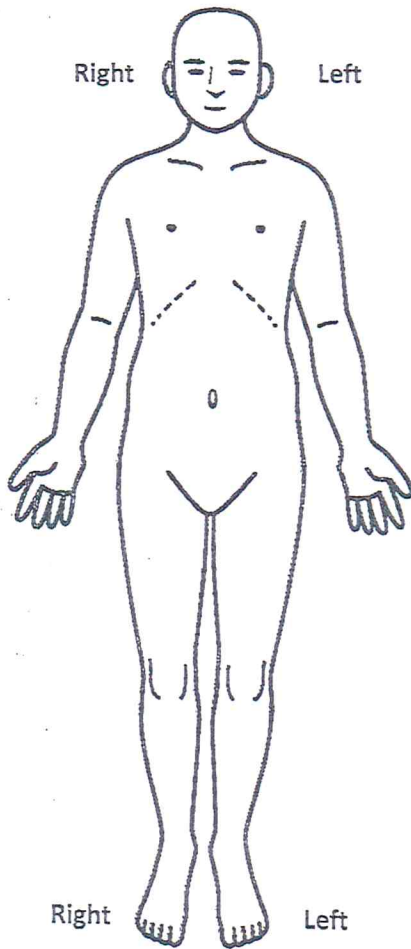
## Body Pain Diagram

In the diagrams provided below, please mark the areas on your body which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include *all* area. Use the symbols provided below.

*Please use the symbols  
In this key to show the  
sensation/pain you  
are feeling.*

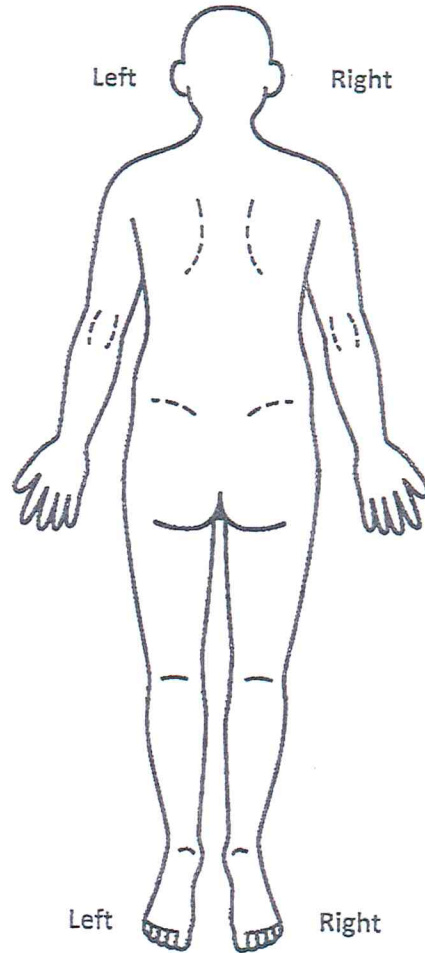
Front

Right Left



Back

Left Right



Numbness

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Burning

Xxxxxxxxxx

Dull/ Aching

+++++++

Pins & Needles

Ooooooooo

Stabbing / Sharp

//////////

Stiff / Tight

2222222

Right Left

Left Right