CONFIDENTIAL HISTORY FORM

In order to give you the highest quality care, please take a few minutes to complete the following questions about your MEDICAL HISTORY. This will become part of your permanent medical record. Thank you.

Name _____ Date: _____

CURRENT COMPLAINTS:
□ Headaches □ Neck Pain □ Arm Pain □ Arm/Hand Numbness □ Mid Back Pain □ Chest Pain □ Low Back Pain □ Buttock Pain □ Hip Pain □ Leg Pain □ Leg/Foot Numbness □ Other: _____

ONSET (How did your pain start?): □ Unknown □ Woke-up with it □ Bending □ Twisting □ Slip/Fall □ Accident

Explain:_____
_____
_____

PAST MEDICAL HISTORY: Please check each box if you have had the following problems:

( ) Diabetes	( ) Stroke	( ) Heart Failure	( ) Arrhythmia	( ) Heart Attack	( ) Pacemaker
( ) Bypass	( ) Ulcer	( ) Dialysis	( ) Angioplasty	( ) Murmur	( ) Reflux
( ) Angina	( ) Headaches	( ) Leg Swelling	( ) Kidney Stones	( ) Hypertension	( ) Obesity
( ) Thyroid	( ) Arthritis	( ) Emphysema	( ) Tuberculosis	( ) Hemophilia	( ) Pneumonia
( ) Cancer – where?		( ) Pass Out	( ) Rheumatic fever	( ) Diverticulosis	( ) Hemorrhoids
_____		( ) Varicose Veins	( ) Impotence	( ) Cholesterol	( ) Asthma
_____		( ) Other _____			

( ) Surgeries _____
_____

FAMILY MEDICAL HISTORY:

Mother:	Age: _____	( ) Living	( ) Deceased
Father:	Age: _____	( ) Living	( ) Deceased
Siblings:	Age: _____	( ) Living	( ) Deceased

Please check each box with the appropriate letter if a family member has (had) the following problems (use M-Mother, F-Father, S-Sibling):

__ Diabetes	__Stroke	__Heart Failure	__Arrhythmia	__Heart Attack	__Pacemaker
__Bypass	__Ulcer	__Dialysis	__Angioplasty	__Murmur	__ Reflux
__Angina	__Headaches	__Leg Swelling	__Kidney Stones	__Hypertension	__Obesity
__Thyroid	__Arthritis	__Emphysema	__Tuberculosis	__Hemophilia	__Pneumonia
__Cancer – where?		__Pass Out	__Rheumatic fever	__Diverticulosis	__Hemorrhoids
_____		__Varicose Veins	__Impotence	__Cholesterol	__Asthma
_____		__Other _____		__Allergies _____	

__Surgeries _____

CURRENT MEDICATIONS:

Name of Medicine	Strength	Dosage

List of known ALLERGIES: _____
_____

( ) Tobacco ( ) Type: _____ ( ) Alcohol Type: _____
( ) Year begun: _____ How often: _____
( ) Still smoking How much: _____
( ) Year quit: _____ How many years: _____
( ) Packs per day: _____

( ) Exercise ( ) None ( ) light ( ) Moderate ( ) Heavy

Other:_____
_____
_____
_____

REVIEW OF SYSTEMS: Do you have (had) the following?:
Check the appropriate box(s)

GENERAL: □ Weight gain □ Weight loss □ Fever □ Hair loss
□ Weakness □ Other: _____

EYES: □ Eye strain □ Wear glasses or contact lenses □ Sensitivity to light

EAR, NOSE,THROAT □ Ringing in ears □ Hearing loss □ Discharge or pain □ Dizziness
□ Runny nose □ Difficulty breathing through nose □ Sinusitis
□ Painful teeth, gums, or palate □ Growths in the mouth
□ Pain or difficulty swallowing □ Hoarseness

CARDIOVASCULAR □ Palpitations □ Chest pain □ Fainting □ Dizziness
□ Varicose veins □ Difficulty climbing Stairs □ Pain in the legs
□ Cold Feet/Hands □ Shortness of breath

RESPIRATORY □ Shortness of breath while walking □ Cough with or without phlegm
□ Asthma/Wheezing □ Spit up blood
□ Other: _____

GASTROINTESTINAL □ Abdominal pain □ Nausea □ Vomiting □ Diarrhea
□ Hemorrhoids □ Change in shape or color of stool

GENITOURINARY □ Discharge □ Pain □ Frequent urination □ Pain with urination

MUSCULOSKELETAL □ Weakness □ Back Pain □ Neck Pain □ Leg Pain
□ Arm Pain □ Shoulder Pain □ Numbness □ Headaches
□ Other: _____

SKIN □ Jaundice □ Dry skin □ Pigment Change □ Growths
□ Moles that have changed color, shape, or bleed

NEUROLOGIC □Tremors □ Weakness □ Numbness □ Memory Loss
□ Confusion □ Other: _____