Name:________________________________ Date:____________________

Presently Employed: __Yes __No Occupation or Previous Occupation:________________

Tobacco use: ___Yes___No No__ Packs/Day___ No of years

Alcohol use: ___Yes___No How often/Amount/type__________________________

Street Drugs ___Yes___No

Marital Status M S D W

Skin: __No Significant History

__Psoriasis __ Eczema __Acne __Other

Hematologic:__No Significant History

__Easy Bruising __Clots

__Easy Bleeding __ Anemia__________________________

HEENT:

__Tinnitus __Dysphagia __Glasses/Contact Lenses

__Visual Disturbances __Hearing Aid __Hair piece/weave

__Discharge __Dentures __Other____________________

Neurological:__ No Significant History

__Headaches __Memory Loss __Back/Neck Pain

__Dizziness __Anxiety/Depression __Numbness

__Paralysis __Fatigue __Weakness

__Seizures __Other______________________________

Cardiovascular: __No Significant History

__Chest Pain __HTN __AICD

__MI __Palpitations __Angina

__Syncope __Pacemaker

__Other______________________Name of Cardiologist:____________________

Gastrointestinal: __ No Significant History

__Change of appetite __Abdominal Pain __Reflux

__Jaundice __Weight Change __Change in Bowel

__Nausea/vomiting __Other______________________________

Urinary: __No Significant History OB/GYN__No Significant History

__Dysuria __Polyuria __Renal Failure __Dysmenorrhea __Possibility of Pregnancy

__Frequency/Hesitancy __Hematuria __Cancer __Other

Endrocrine: __No Significant History

__Heat/Cold Intolerance __Adrenal Problems __Scleroderma __Rheumatoid Arthritis

__Thyroid Problems __Pituitary Problems __Lupus

Pulmonary: __ No Significant History

__SOB __Pneumonia __Orthopnea

__TB __Asthma __Hemoptysis

__Cough __DOE __Emphysema

__Sleep Apnea __Oxygen at Home __Other____________________

Musculoskeletal: __No Significant History

__Pain __DVT __Cane/Walker __Arthritis

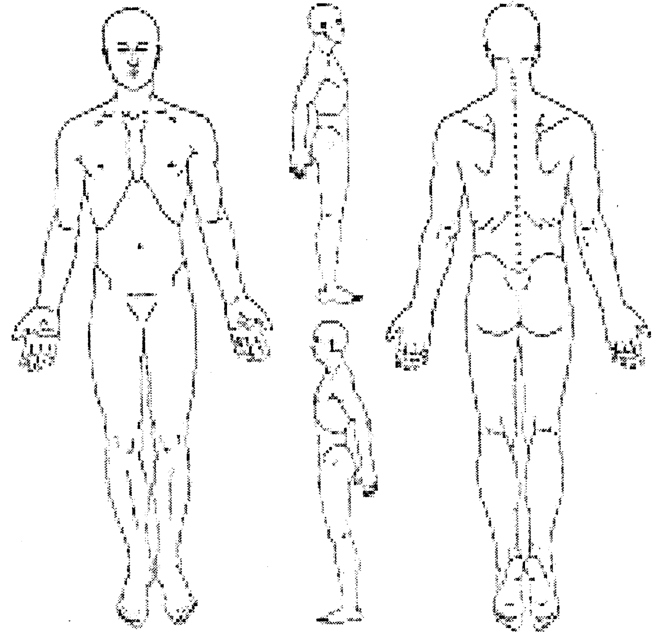
__Swelling __Wheel Chair

__Prosthesis/Implants/Artificial Joints __Yes __No Type:________________

Body Piercing: __Yes __No Where?____________________

Name: ______________________________ Date: ________________

Please mark on the diagram the location of the pain.



Please describe the type of pain or sensation you are currently experiencing.
(circle all that apply)

○ Aching ○ Shooting

○ Burning ○ Stabbing

○ Cramps ○ Stiffness

○ Dull ○ Swelling

○ Numbness ○ Throbbing

○ Sharp ○ Tingling

○ Spasms ○ Weakness

○ Other, Describe ______________________

Please place a mark on the line that corresponds to your current pain.

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAINT EVER

Please place a mark on the line that corresponds to your average pain.

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAINT EVER

- When did the pain begin? __________ Since onset, is pain getting better or worse?

  ____

- What brought the pain on? Was it an event or injury?

  ____

- The pain is (circle all that apply):

  ○ Constant ○ Intermittent ○ Occasional

If it is intermittent or occasional, how often does the pain exist?
And for how long?

____

- Does it interfere with your:

  ○ Work ○ Sleep ○ Daily Routine ○ Recreation

  ○ Other ______________________________

- Activities or movement that are painful to perform and/or increase pain:

  ○ Sitting ○ Standing ○ Walking ○ Bending ○ Lying Down

  ○ None ○ Other __________________________________

- What makes the pain better?

  ____

- What medications are you taking for this pain?

  ____

- Any prior injuries to the area of pain?

  ____

- What, if any, treatments have you received for this pain?

  ____

- **Please list any current medications you are taking on a daily or routine basis.**

  ____

- **Please list any surgeries you have had.**

  ____

Medical History Name: ____________________ DOB: ___________ Date: _____________

Check all that apply:

Head
- ○ Trauma

Mouth/Throat/Teeth
- ○ Dentures

OB/GYN
- ○ Possibility of pregnancy

Eyes
- ○ Blindness
- ○ Cataracts
- ○ Glaucoma
- ○ Wears glasses/contacts
- ○ Visual disturbances

Ears
- ○ Hearing aids
- ○ Nose/sinuses
- ○ Allergic Rhinitis
- ○ Sinus infections
- ○ Tinnitus

Psychiatric
- ○ Bipolar Disorder
- ○ Depression
- ○ Hallucinations, delusions
- ○ Suicidal ideation
- ○ Suicide attempts

Skin
- ○ Acne
- ○ Eczema
- ○ Dermatitis
- ○ Mole(s)
- ○ Psoriasis
- ○ Skin condition(s)

Genitourinary
- ○ STDs
- ○ UTI(s)
- ○ Hernia
- ○ Incontinence
- ○ Other kidney disease

Tobacco Use
- ○ Never smoker
- ○ Former smoker
- ○ Light tobacco smoker
- ○ Heavy tobacco smoker
- ○ Current every day smoker
- ○ Current some day smoker

Alcohol Drug Use
- ○ Drink daily
- ○ Do not drink
- ○ Frequently drink
- ○ Hx of alcoholism
- ○ Occasional drink

Street Drug Use
- ○ IVDU
- ○ Illicit drug use
- ○ No illicit drug use

Cardiovascular
- ○ Balanced diet
- ○ Regularly active
- ○ Not active

Musculoskeletal
- ○ DVT
- ○ Gout
- ○ Scoliosis
- ○ Prosthesis
- ○ Arthritis
- ○ M/S injury
- ○ Fibromyalgia
- ○ Osteoporosis
- ○ Wheelchair/cane

Heme/One
- ○ HIV
- ○ Anemia
- ○ Infectious
- ○ Cancer type
- ○ Tuberculosis (dz)
- ○ Tuberculosis (exposure)

Neurological
- ○ TIA
- ○ Stroke
- ○ Vertigo
- ○ Seizures
- ○ Epilepsy
- ○ Paralysis
- ○ Narcolepsy
- ○ Severe headaches, migraines

Medical History Name: ____________________ DOB: ___________ Date: _____________

Check all that apply:

Respiratory

- ○ TB
- ○ Asthma
- ○ DOE
- ○ Pleuritis
- ○ Bronchitis
- ○ Hemoptysis
- ○ Orthopnea
- ○ Sleep apnea
- ○ Pneumonia
- ○ Oxygen at home
- ○ COPD / Emphysema

Cardiovascular

- ○ DVT
- ○ HTN
- ○ AICD
- ○ Murmur
- ○ Angina
- ○ Aneurysm
- ○ Syncope
- ○ Pacemaker
- ○ Hypertension
- ○ Palpitations
- ○ Dysrhythmia
- ○ Myocardial infarction
- ○ Hypercholesterol
- ○ Other heart disease

Endocrine

- ○ Lupus
- ○ Golter
- ○ Thyroiditis
- ○ Thyroid disease
- ○ Scleroderma
- ○ Hypothyroidism
- ○ Hyperlipidemia
- ○ Adrenal Problems
- ○ Pituitary problems
- ○ Rheumatoid Arthritis
- ○ Type I Diabetes
- ○ Type II Diabetes

Gastrointestinal

- ○ GERD
- ○ Ulcer
- ○ Reflux
- ○ Jaundice
- ○ Hepatitis
- ○ Cirrhosis
- ○ Heartburn
- ○ Hiatal hernia
- ○ Hemorrhoids
- ○ Diverticulitis
- ○ Gallbladder disease

Additional Symptoms

- ○ Coughing
- ○ Dizziness
- ○ Easy bruising
- ○ Easy bleeding
- ○ Weight change
- ○ Appetite change
- ○ Memory loss
- ○ Nausea / vomiting

Medical History Name: ____________________ DOB: ___________ Date: ______________

Please circle if anyone in your family has the following and list family members.

Birth defects ○ Yes ○ No ________________

Breast Disease ○ Yes ○ No ________________

Cancer ○ Yes ○ No ________________

Diabetes ○ Yes ○ No ________________

Stroke ○ Yes ○ No ________________

Heart Attack ○ Yes ○ No ________________

Heart Disease ○ Yes ○ No ________________

Osteoporosis ○ Yes ○ No ________________

High Blood Pressure ○ Yes ○ No ________________

High Cholesterol ○ Yes ○ No ________________

Bleeding Disorder ○ Yes ○ No ________________

Other ○ Yes ○ No ________________

For those listed indicate living or deceased.

Deceased	Living	
○	○	________________
○	○	________________
○	○	________________
○	○	________________
○	○	________________
○	○	________________