

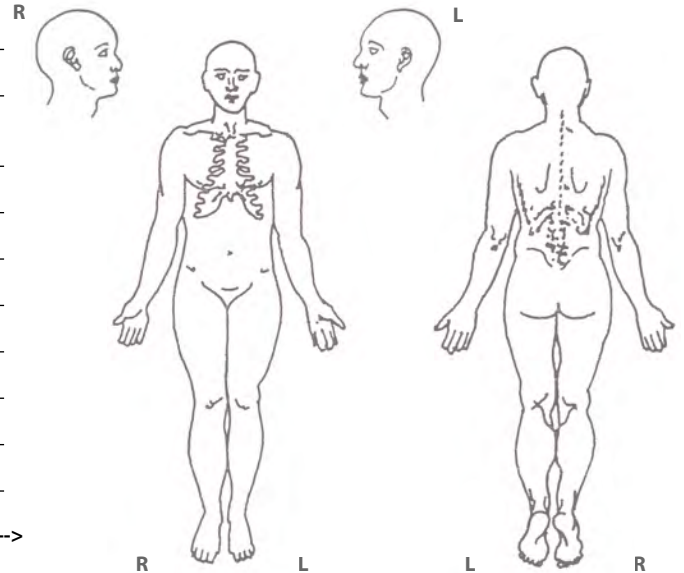
Name _____ Handedness: **R** **L** Sex M F Age: _____ Date of Birth: _____

Referring Physician or self: _____ Other Physicians: _____ Today's Date _____

HISTORY OF PRESENT ILLNESS AND CURRENT SYMPTOMS

Main Medical Symptom: _____

Please tell us in detail why you are here today: _____



Mark in the drawings to the right areas you have symptoms or discomfort --->

PAST MEDICAL HISTORY

Please mark any illnesses you have now or have had in the past:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headache/Migraines | <input type="checkbox"/> Nerve injury | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Neck or back injury | <input type="checkbox"/> Muscle disease | <input type="checkbox"/> Lung disease/Asthma |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Cancer. Type? _____ | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Depression/Bi-polar | <input type="checkbox"/> Brain tumor | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Ulcers/GI Bleeding | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Other Mental Illnesses | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Other _____ |

Please elaborate if necessary: _____

MEDICATIONS

Name	Dose	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SURGERIES AND HOSPITALIZATIONS

DRUG ALLERGIES

Name of drug	Type of reaction
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

Marital or Living Situation _____ Do you have children? _____
 Occupation _____ Are you disabled? _____
 Do you smoke? Never Quit: How long ago? _____ Presently smoke: How much? _____
 Do you drink alcohol? Yes No Quit: Year _____ If yes, approximately how many drinks per week? _____ Wine _____ Beer _____ Hard liquor _____
 Environment Hazards, Poisons or Street Drugs? _____

FAMILY HISTORY

Father's Age: _____ Deceased? _____ Mother's Age: _____ Deceased? _____
Please list which family members (including parents, grandparents, siblings, children, aunts and uncles) have been afflicted next to each checked disorder:
 Diabetes _____ Neuropathy _____ Alzheimer's Disease _____
 High Blood Pressure _____ Parkinson's Disease _____ Brain Aneurysm _____
 Heart Disease _____ Tremors _____ Multiple Sclerosis _____
 Strokes, approx. age _____ Seizures _____ Depression or other Mental Illness _____
 Cancer, Type _____ Migraines _____ Carpal Tunnel Syndrome _____

REVIEW OF SYSTEMS

CIRCLE AND EXPLAIN:

Constitutional: Fevers, Sweats, Loss Of Appetite, Rapid Weight Loss Or Weight Gain, Fatigue, Insomnia, Daytime Sleepiness _____
 Vision: Blurred, Double, Blindness _____
 Ear, Nose, Throat: Headache, Loss Of Smell, Vertigo, Lightheadedness, Dizziness, Earache, Deafness, Ringing, Slurred Speech, Hoarse Voice, Poor Swallowing _____
 Cardiovascular: Chest Pain, Palpitations, Murmur, Ankle Swelling _____
 Respiratory: Shortness Of Breath, Asthma, Bronchitis, Cough, Loud Snoring _____
 Gastrointestinal: Abdominal Pain, Diarrhea, Constipation, Bleeding, Nausea, Loss of Bowel Control, Vomiting, Jaundice, Hepatitis _____
 Genito-urinary: Loss Of Bladder Control, Menstrual Irregularities, Prostate _____
 Musculoskeletal: Joint Pain, Neck Pain, Back Pain, Arm (Pain / Tingling / Numbness), Leg (Pain / Tingling / Numbness) _____
 Skin: Rash, Itching, Lumps, Discoloration _____
 Neurological: Forgetfulness, Poor Concentration, Confusion, Disorientation _____
 Seizures, Fainting, Slow Movements, Tremors _____
 Poor Balance, Falls, Limping, Weak Arm, Weak Leg _____
 Restless Legs At Night, Burning Pain In The Feet _____
 Endocrine: Goiter, increased thirst _____
 Hematologic: Bruising, Bleeding, Anemia _____
 Allergy/Immune: Seasonal Allergies, Food Allergies _____
 Psychiatric: Depression, Anxiety, Hallucinations, Personality Change, Lack Of Interest, Low Energy, Irritability, Aggressiveness, Agitation _____

Are you pregnant? Y N Do you use a birth control method? Y N *Please inform the doctor/nurse if you might become pregnant in the next year.*