



MEDICAL HISTORY

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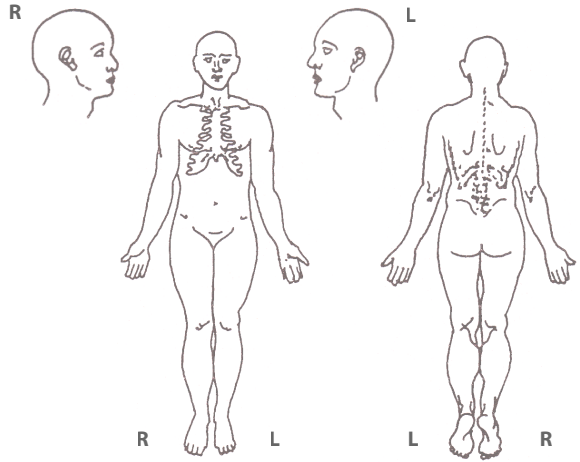
Name _____ Right-handed / Left-handed Sex M F Age: _____ Date of Birth: _____

Referring Physician or self: _____ PCP: _____ Appointment 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"/> Neck injury | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Back injury | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Cancer. Type? _____ | <input type="checkbox"/> Brain tumor |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Depression | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Bi-polar | <input type="checkbox"/> GI Bleeding |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Other Mental Illness _____ | <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> On CPAP |
| <input type="checkbox"/> TIA | <input type="checkbox"/> Restless Leg Syndrome | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Dementia | <input type="checkbox"/> Lung disease/Asthma |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Head injury | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Muscle disease | <input type="checkbox"/> Other _____ |

SURGERIES

Please elaborate if necessary: _____

PRESCRIPTION MEDICATIONS

| Name | Dose (mg) | How often? |
|-------|-----------|------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

NON-PRESCRIPTION MEDICATIONS

DRUG ALLERGIES

| Name of drug | Type of reaction |
|--------------|------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

MEDICAL HISTORY (page 2 of 2)

Name _____

SOCIAL HISTORY

Are you: Married Single Widowed Divorced Domestic Partner Do you have children? _____ Ages? _____

Living: With family With roommate(s) Alone Assisted Living Foster Home

Occupation (current or before retirement) _____ If on Disability: Cause _____

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 _____

Environmental Hazards or Poisons? _____ Previous or current use of illicit drugs _____

FAMILY HISTORY (OTHER THAN YOU)

Father's Age: _____ Deceased? _____ Mother's Age: _____ Deceased? _____

Please list which family members (including mother, father, grandmother, grandfather, brothers, sisters, children, aunts and uncles) have been afflicted next to each checked disorder:

| | | |
|---|--|---|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Neuropathy _____ | <input type="checkbox"/> Alzheimer's Disease _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Parkinson's Disease _____ | <input type="checkbox"/> Brain Aneurysm _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Tremors _____ | <input type="checkbox"/> Multiple Sclerosis _____ |
| <input type="checkbox"/> Strokes, approx. age _____ | <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Depression or other Mental Illness _____ |
| <input type="checkbox"/> Cancer, Type _____ | <input type="checkbox"/> Migraines _____ | <input type="checkbox"/> Carpal Tunnel Syndrome _____ |

REVIEW OF SYSTEMS

CHECK BOX IF NONE

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.