

CONFIDENTIAL PATIENT CASE HISTORY

Name _____ Birthday _____ Sex M F
 Address _____ City/State _____ Zip _____
 Soc. Sec. # _____ Cell _____ E-Mail _____
 Marital Status: M D S W Children, Ages _____ Spouse's Name _____
 Occupation _____ Employer _____
 Emergency Contact _____ Relationship _____ Phone Number _____
 Who referred you to us? _____ How else did you hear about us? _____

HISTORY OF CURRENT SYMPTOMS

What is your major complaint? _____

 How long have you had this condition? _____
 Have you had this or similar conditions in the past? _____
 Do any positions make it feel worse? _____
 Do any positions make it feel better? _____
 Is this condition: Improved Unchanged Getting Worse
 Is this condition interfering with your: Work Sleep Daily Routine Other _____
 Other doctors or therapists who have treated THIS condition _____
 What do you think caused this condition? _____

MARK YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT.

Use the following Symbols:

Aches XXXX Numbness OOOO Pins/Needles ●●● Stabbing ////

MARK AN "X" ON THE LINES BELOW:

How bad are your symptoms now?
 None ----- Most Severe
 How bad have they been in the past?
 None ----- Most Severe
 Frequency: Occasional (0-25%) Intermittent (25-50%)
 Frequent (50-75%) Constant (75-100%)



Signature _____ Date _____

Patient Name _____

Date _____

HEALTH HISTORY Check only the ones you now have or have had in the past.

GENERAL **NOW** **PAST**

- Weakness N P
- Fatigue N P
- Fever N P
- Chills N P
- Night Sweats N P
- Fainting N P

SKIN

- Color Changes N P
- Nail Changes N P
- Hair Changes N P
- Rashes N P
- Sores N P
- Weakness N P

HEAD

- Headaches N P
- Injuries N P
- Bumps N P
- Last Eye Exam _____
- Glasses N P
- Contacts N P
- Cataracts N P

EARS

- Hard of Hearing N P
- Deafness N P
- Ringing N P
- Discharge N P
- Earache N P
- Dizziness N P
- Room Spins N P

NOSE

- Decreased Smell N P
- Bleeding N P
- Pain N P
- Discharge N P
- Obstruction N P
- Post Nasal Drip N P
- Deviated Septum N P
- Runny Nose N P
- Sinus Congestion N P

MOUTH

- Bleeding Gums N P
- Sores N P
- Dental Problems N P
- Bad Breath N P
- Loss of Taste N P
- Dry Mouth N P
- Ulcers / Blisters N P

THROAT **NOW** **PAST**

- Soreness N P
- Bad Tonsils N P
- Hoarseness N P
- Pain N P
- Trouble Swallowing N P
- Recurrent Infections N P

NECK

- Neck Enlargement N P
- Stiff neck N P
- Soreness N P
- Lumps N P
- Masses N P

BREAST

- Discharge N P
- Lumps N P
- Pain N P
- Bleeding N P
- Nipple Changes N P
- Skin Changes N P

LUNGS

- Cough N P
- Phlegm N P
- Blood N P
- Short of Breath N P
- Wheezing N P
- Pain N P
- Congestion N P
- Inhalant Exposure N P

HEART

- Murmur N P
- Palpitations N P
- Rapid Heartbeat N P
- Swollen Extremities N P
- Cold Extremities N P
- Chest Pain/Pressure N P
- Varicose Veins N P
- Blood Clots N P
- Blue Extremities N P

BLOOD

- Anemia N P
- Low Blood Iron N P
- Easy Bruising N P
- Easy Bleeding N P
- Swollen Nodes N P
- Painful Nodes N P
- Sugar in Blood N P
- Red Spots N P

GASTROINTESTINAL **NOW** **PAST**

- Abdominal Pain N P
- Nausea N P
- Bloated N P
- Belching N P
- Heartburn N P
- Indigestion N P
- Irregular Bowel N P
- Constipation N P
- Diarrhea N P
- Gas N P
- Hemorrhoids N P
- Poor Appetite N P
- Food Intolerance N P
- Bloody Stools N P
- Black Stools N P

GENITOURINARY

- Urgency N P
- Incontinence N P
- Straining N P
- Frequent Voiding N P
- Stones N P
- Burning N P
- Small Stream N P
- Discharge N P
- Impotence N P
- Dribbling N P
- Cloudy Urine N P
- Urine Color _____
- Spotting Between _____
- Periods N P
- Itching N P
- Painful Intercourse N P
- Hot Flashes N P
- Contraception Type _____
- Age at First Period _____
- No. of Pregnancies _____
- No. of Births _____
- No. of Miscarriages _____
- No. of Abortions _____
- Last Period _____
- Last Pap Smear _____
- Last Mammogram _____
- Last Prostate Exam _____

Patient Name _____

Date _____

HEALTH HISTORY Check only the ones you now have or have had in the past.

NEUROLOGIC	NOW	PAST
Seizures	<input type="checkbox"/> N	<input type="checkbox"/> P
Vertigo	<input type="checkbox"/> N	<input type="checkbox"/> P
Dizziness	<input type="checkbox"/> N	<input type="checkbox"/> P
Hand Trembling	<input type="checkbox"/> N	<input type="checkbox"/> P
Loss of Sensation	<input type="checkbox"/> N	<input type="checkbox"/> P
Incoordination	<input type="checkbox"/> N	<input type="checkbox"/> P
Facial Weakness	<input type="checkbox"/> N	<input type="checkbox"/> P
Weak Grip	<input type="checkbox"/> N	<input type="checkbox"/> P
Paralysis	<input type="checkbox"/> N	<input type="checkbox"/> P
Difficulty Speech	<input type="checkbox"/> N	<input type="checkbox"/> P
Tingling	<input type="checkbox"/> N	<input type="checkbox"/> P
Loss of Memory	<input type="checkbox"/> N	<input type="checkbox"/> P
Numbness	<input type="checkbox"/> N	<input type="checkbox"/> P

PSYCHIATRIC	NOW	PAST
Hyperventilation	<input type="checkbox"/> N	<input type="checkbox"/> P
Insecurity	<input type="checkbox"/> N	<input type="checkbox"/> P
Depression	<input type="checkbox"/> N	<input type="checkbox"/> P
Trouble Sleeping	<input type="checkbox"/> N	<input type="checkbox"/> P
Irritable	<input type="checkbox"/> N	<input type="checkbox"/> P
Timid	<input type="checkbox"/> N	<input type="checkbox"/> P
Hallucinations	<input type="checkbox"/> N	<input type="checkbox"/> P
Loss of Memory	<input type="checkbox"/> N	<input type="checkbox"/> P
Alcoholism	<input type="checkbox"/> N	<input type="checkbox"/> P
Drug Addiction	<input type="checkbox"/> N	<input type="checkbox"/> P
Suicidal Thoughts	<input type="checkbox"/> N	<input type="checkbox"/> P
Extreme Worry	<input type="checkbox"/> N	<input type="checkbox"/> P
Sexual Problems	<input type="checkbox"/> N	<input type="checkbox"/> P

MUSCULOSKELETAL	NOW	PAST
Muscle Pain	<input type="checkbox"/> N	<input type="checkbox"/> P
Muscle Weakness	<input type="checkbox"/> N	<input type="checkbox"/> P
Muscle Cramps	<input type="checkbox"/> N	<input type="checkbox"/> P
Muscle Twitching	<input type="checkbox"/> N	<input type="checkbox"/> P
Joint Stiffness	<input type="checkbox"/> N	<input type="checkbox"/> P
Joint Pain	<input type="checkbox"/> N	<input type="checkbox"/> P

ENDOCRINE	NOW	PAST
Weight Loss	<input type="checkbox"/> N	<input type="checkbox"/> P
Weight Gain	<input type="checkbox"/> N	<input type="checkbox"/> P
Extremely Thin	<input type="checkbox"/> N	<input type="checkbox"/> P
Heat Intolerance	<input type="checkbox"/> N	<input type="checkbox"/> P
Cold Intolerance	<input type="checkbox"/> N	<input type="checkbox"/> P
Hair Changes	<input type="checkbox"/> N	<input type="checkbox"/> P
Breast Changes	<input type="checkbox"/> N	<input type="checkbox"/> P

PAST MEDICAL HISTORY. Check only the ones you have had in the past.

Hay Fever	<input type="checkbox"/> Y	Parasites	<input type="checkbox"/> Y
Mumps	<input type="checkbox"/> Y	Epilepsy	<input type="checkbox"/> Y
Rheumatic Fever	<input type="checkbox"/> Y	Paralysis	<input type="checkbox"/> Y
Allergies	<input type="checkbox"/> Y	Polio	<input type="checkbox"/> Y
Angina	<input type="checkbox"/> Y	Mental Illness	<input type="checkbox"/> Y
Cancer	<input type="checkbox"/> Y	Alcoholism	<input type="checkbox"/> Y
Tumor	<input type="checkbox"/> Y	Depression	<input type="checkbox"/> Y
Blood Disease	<input type="checkbox"/> Y	Nervous Breakdown	<input type="checkbox"/> Y
Leukemia	<input type="checkbox"/> Y	Migraine	<input type="checkbox"/> Y
Heart Trouble	<input type="checkbox"/> Y	Gout	<input type="checkbox"/> Y
Varicose Veins	<input type="checkbox"/> Y	Hemorrhoids	<input type="checkbox"/> Y
Phlebitis	<input type="checkbox"/> Y	Prostate Problems	<input type="checkbox"/> Y
Hypertension	<input type="checkbox"/> Y	Sexual Problems	<input type="checkbox"/> Y
Stroke	<input type="checkbox"/> Y	Gonorrhea	<input type="checkbox"/> Y
Ulcers	<input type="checkbox"/> Y	Syphilis	<input type="checkbox"/> Y
Jaundice	<input type="checkbox"/> Y	Diabetes	<input type="checkbox"/> Y
Skin Trouble	<input type="checkbox"/> Y	Bladder Trouble	<input type="checkbox"/> Y
Gallstones	<input type="checkbox"/> Y	Kidney Stones	<input type="checkbox"/> Y
Liver Trouble	<input type="checkbox"/> Y	Kidney Infections	<input type="checkbox"/> Y
Hepatitis	<input type="checkbox"/> Y	Dysentery	<input type="checkbox"/> Y

IMMUNIZATION/VACCINATION

DPT	<input type="checkbox"/> Y
Mumps	<input type="checkbox"/> Y
Smallpox	<input type="checkbox"/> Y
Typhoid	<input type="checkbox"/> Y
Tetanus	<input type="checkbox"/> Y
Measles	<input type="checkbox"/> Y
Pneumococcal	<input type="checkbox"/> Y
Influenza	<input type="checkbox"/> Y
Polio	<input type="checkbox"/> Y
MMR	<input type="checkbox"/> Y

BLOOD TYPE

A+ <input type="checkbox"/>	A- <input type="checkbox"/>
B+ <input type="checkbox"/>	B- <input type="checkbox"/>
AB+ <input type="checkbox"/>	AB- <input type="checkbox"/>
O+ <input type="checkbox"/>	O- <input type="checkbox"/>
Other _____	

Date of Last Chest X-Ray _____ Normal Abnormal

Date of Last TB Skin Test _____ Normal Abnormal

Allergies _____

BLOOD TRANSFUSIONS

Date _____

Date _____

Date _____

Patient Name _____

Date _____

HEALTH HISTORY

List any surgical operation and years: _____

List any hospitalization and years: _____

Do you have a family physician? Name: _____

Medications, dosage, and frequency: _____

Have you been in an auto accident or had any other personal injury? Y N

If yes, describe: _____

FAMILY HISTORY List any of the conditions previously listed which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses/Conditions
<u>Father</u>	_____	_____	_____	_____	_____
<u>Mother</u>	_____	_____	_____	_____	_____
<u>Brother(s)</u>	_____	_____	_____	_____	_____
<u>Sister(s)</u>	_____	_____	_____	_____	_____
<u>Mat. Grandfather</u>	_____	_____	_____	_____	_____
<u>Mat. Grandmother</u>	_____	_____	_____	_____	_____
<u>Pat. Grandfather</u>	_____	_____	_____	_____	_____
<u>Pat. Grandmother</u>	_____	_____	_____	_____	_____

SOCIAL HISTORY Check the boxes and fill in accordingly.

Height _____ Weight _____ lbs. Have you recently lost or gained weight? _____

Mental Work Heavy Moderate Light Hours per day _____

Physical Work Heavy Moderate Light Hours per day _____

Exercise Heavy Moderate Light Hours per day _____

Smoking Current Previous Packs/Day _____ No. of Years _____

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

Caffeine Cups/Day _____ No. of Years _____

Aspirin No./Day _____ No. of Years _____