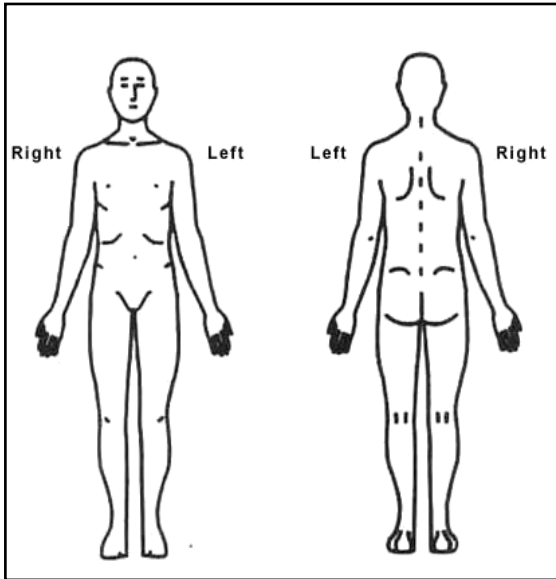


History Form

Name: _____ Age: _____
Height: _____ Weight: _____ Referring Physician: _____
Reason for today's visit: _____



- On a scale of 0 to 10, what is your pain today _____
- Describe the quality of your pain, *please circle all that apply*:
Aching Gnawing Pressure Stinging Drilling Heaviness Raw
Throbbing Burning Tightness Cold Nagging Shock-like Sharp
Exhausting Cramping Penetrating Shooting Other: _____
- Does the pain radiate? _____ Yes _____ No
If "yes", where does the pain radiate to: _____
- How long has the current condition been present? _____
Date of onset: _____
- How did the problem begin? Gradual onset Sudden onset After surgery
Accident / Injury Accident / Injury date: _____
Please describe the accident / injury: _____
- Injury / Illness aggravated by: _____
Injury / Illness Relieved by: _____
- Have you had a problem like this in the past? If so, when? _____
- Please list all the diagnostic tests and treatments that have been performed for the problem that we are seeing you for today (please provide when / where / what): _____

REVIEW OF SYSTEMS

Please circle **Yes** or **No** for each symptom listed below. **Do not leave any blanks.**

Constitutional

Recent Weight Changes	Yes	No
Chills or Fever	Yes	No
Fatigue	Yes	No
Hot or Cold Spells	Yes	No

Respiratory

Morning Cough	Yes	No
Shortness of Breath	Yes	No

Cardiovascular

Heart or Chest Pain	Yes	No
Abnormal Heartbeat	Yes	No
Badly Swollen Ankles	Yes	No
Calf Cramps	Yes	No

Gastrointestinal

Poor Appetite	Yes	No
Nausea/ Vomiting	Yes	No
Abdominal Pain	Yes	No
Constipation/ Diarrhea	Yes	No

Endocrinologic

Intolerance to Heat & Cold	Yes	No
Menstrual Irregularities	Yes	No
Frequent Hunger/Thirst/Urination	Yes	No

Musculoskeletal

Joint Pain/Swelling	Yes	No
Joint Stiffness	Yes	No
Limited Use of a Joint	Yes	No
Bone Deformities	Yes	No
Muscle Cramping/Pain	Yes	No
Loss of Muscle Strength	Yes	No

Genitourinary

Frequent Urination	Yes	No
Burning on Urination	Yes	No
Incontinence	Yes	No

Neurological

Frequent Headaches	Yes	No
Blackouts	Yes	No
Seizures	Yes	No
Tremors	Yes	No
Loss of Bowel	Yes	No
Difficulty Balance	Yes	No

Immunologic

Seasonal Allergies	Yes	No
Frequent Infections	Yes	No
HIV Exposure	Yes	No



History Form



Integumentary

Rashes	Yes	No
Lumps	Yes	No
Itching	Yes	No
Dryness	Yes	No

Psychiatric

Anxiety	Yes	No
Depression	Yes	No
Memory Loss	Yes	No
Stress	Yes	No

Hematologic

Excessive Bleeding	Yes	No
Easy Bruising	Yes	No
Anemia	Yes	No

HEENT

Difficulty Hearing	Yes	No
Ringing in Ears	Yes	No
Sore Throat	Yes	No
Nasal Bleeding	Yes	No

PATIENT'S MEDICAL HISTORY Please circle all that apply.

AIDS/HIV, Alcoholism, Alzheimer's, Anemia, Angina, Arthritis, Asthma, Atrial Fibrillation, Benign Prostatic Hypertrophy, Cancer, Congestive Heart Failure, COPD, Coronary Heart Disease, Crohn's Disease, Depression, Degenerative Joint Disease, Diabetes, Drug Abuse, DVT, Fibromyalgia, Gallbladder Disease, GERD, Gout, Hepatitis, Hyperlipidemia, Hypertension, Inflammatory Bowel Disease, Juvenile Rheumatoid Arthritis, Kidney Disease, Liver Disease, Lyme Disease, Migraine Headaches, Myocardial Infarction (heart attack), Obesity, Osteoporosis, Peptic Ulcer Disease, Psoriasis, PVD, Renal Disease, Rheumatoid Arthritis, Scoliosis, Seizure Disorder, SLE (Lupus), Sleep Apnea, Stroke, Thyroid Disease,

NONE

OTHER: _____

SOCIAL HISTORY Please circle all that apply.

Smoking or use of tobacco products: Never Former Years of use _____ Number of packs or products per day _____ Date Last Used _____

Alcohol: None Occasionally Recreationally Everyday Recreational Drug Use: None Occasionally Presently Past Problem

Hand Dominance: Right Left Ambidextrous

SURGICAL HISTORY

Please include approximate dates.

No Prior Surgeries

ALLERGIES

Medication / Other Substance:	Reaction:	Severity of Allergy:	(please circle)
_____	_____	Mild Moderate Severe Intolerable	
_____	_____	Mild Moderate Severe Intolerable	
_____	_____	Mild Moderate Severe Intolerable	
_____	_____	Mild Moderate Severe Intolerable	

CURRENT MEDICATION LIST

Please include all medications prescribed by a physician, any over-the-counter (OTC) medications, any herbal supplements, and vitamins.

NONE

PREFERRED PHARMACY NAME AND LOCATION