

COMPLETE HISTORY FORM

Date: _____

DOB: _____ Patient Name: _____ Age: _____

Who is your Family/Primary Care Physician? _____

If referred to this office, full name of referring physician _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Who referred you for this problem? _____

Current problem is a result of a(n): *Check all that apply*

- Car Accident Work Accident Home Accident Chronic Problem Other _____

Date this began bothering you: _____

How did accident happen? _____

Where did accident happen? _____

What makes it feel worse? _____

What makes it feel better? _____

How far can you walk without stopping? _____

Back/Hip/Leg Patients: Any change in bowel or bladder function? No Yes _____

Have you seen any other doctor for this problem? _____ If yes, who? _____

Have you had any prior surgery for this problem? (surgeon's name and dates) _____

Have you had any prior treatment for this problem? No Yes If yes, please mark appropriate treatments:

Physical Therapy – Where _____ When: _____ Injections – Where _____ When: _____

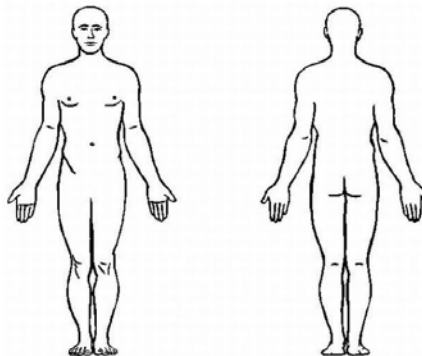
X-rays – Where _____ When: _____ Nerve Tests – Where _____ When: _____

MRI – Where _____ When: _____ Other _____ - Where _____ When: _____

CAT Scan – Where _____ When: _____

Please shade in the area where your symptoms are on the diagram below

- Symbols:*
ACHE ±
NUMBNESS ◯
PINS/NEEDLES ...
STABBING ///



How would you rate your pain today on a scale of 0 – 10 (circle on scale) 0 _____ 10
No Pain 1 2 3 4 5 6 7 8 9 Most Pain

REVIEW OF SYSTEMS:

Are you currently having or have you ever had problems with your:

	Circle	Describe yes responses		Circle	Describe yes responses
Eyes	No Yes	_____	Balance Problems	No Yes	_____
Ears, Nose, Throat	No Yes	_____	Numbness/Tingling	No Yes	_____
Lungs, Breathing	No Yes	_____	Blackout/Fainting	No Yes	_____
Digestion	No Yes	_____	Mood/Sleep problems	No Yes	_____
Bowel Movements	No Yes	_____	Autoimmune Disease	No Yes	_____
Bladder Problems	No Yes	_____	Rheumatoid Arthritis	No Yes	_____
Diabetes	No Yes	_____	Seizures/Epilepsy	No Yes	_____
High Blood Pressure	No Yes	_____	Cancer	No Yes	_____
Heart Condition(s)	No Yes	_____	TB	No Yes	_____
Bleeding Problems	No Yes	_____	Polio	No Yes	_____

If you are a female, are you pregnant or do you think you may be pregnant? No Yes

PAST MEDICAL HISTORY

Year(s) Doctor(s) Complications

Surgeries/Hospitalizations: _____

List all current medicines and dosage: _____

Have you ever had *general anesthesia*? No Yes Had any problems with anesthesia? No Yes

ALLERGIC to Latex? No Yes **ALLERGIES** to Medications? No Yes List: _____

SOCIAL HISTORY

Work in the home Employed (occupation _____) Student Daycare Retired

Single Married Divorced Separated Widowed

Children? No Yes # _____ Do you live alone? No Yes

Exercise? Daily Weekly Monthly Rarely Never

What type of exercise? _____

History of substance abuse? _____

Smoke currently? No Yes Packs per day _____ for _____ years

Quit smoking? This year less than 1 year less than 5 years less than 10 years

Previously smoked _____ packs per day for _____ years

Drink alcohol? No Daily 1 – 2 times a week 1– 2 times a month 1 – 2 times a year

FAMILY HISTORY

	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		_____
Grandmother (dad's)	A	D		_____
Grandfather (mom's)	A	D		_____
Grandfather (dad's)	A	D		_____
Father	A	D		_____
Mother	A	D		_____
Sister/Brother	A	D		_____
Sister/Brother	A	D		_____
Sister/Brother	A	D		_____

Signature: _____ Date _____