CONFIDENTIAL HISTORY FORM

In order to give you the highest quality care, please take a few minutes to complete the following questions about your MEDICAL HISTORY. This will become part of your permanent medical record. Thank you.

Name ____ Date: ____________________

CURRENT COMPLAINTS:
□ Headaches □ Neck Pain □ Arm Pain □ Arm/Hand Numbness □ Mid Back Pain □ Chest Pain □ Low Back Pain □ Buttock Pain □ Hip Pain □ Leg Pain □ Leg/Foot Numbness □ Other: ______________________________

ONSET (How did your pain start?): □ Unknown □ Woke-up with it □ Bending □ Twisting □ Slip/Fall □ Accident

Explain:____

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PAST MEDICAL HISTORY: Please check each box if you have had the following problems:

( ) Diabetes ( ) Stroke ( ) Heart Failure ( ) Arrhythmia ( ) Heart Attack ( ) Pacemaker
( ) Bypass ( ) Ulcer ( ) Dialysis ( ) Angioplasty ( ) Murmur ( ) Reflux
( ) Angina ( ) Headaches ( ) Leg Swelling ( ) Kidney Stones ( ) Hypertension ( ) Obesity
( ) Thyroid ( ) Arthritis ( ) Emphysema ( ) Tuberculosis ( ) Hemophilia ( ) Pneumonia
( ) Cancer – where? ( ) Pass Out ( ) Rheumatic fever ( ) Diverticulosis ( ) Hemorrhoids
______________________ ( ) Varicose Veins ( ) Impotence ( ) Cholesterol ( ) Asthma
______________________ ( ) Other ____
( ) Surgeries ____

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FAMILY MEDICAL HISTORY:

Mother: Age: ________ ( ) Living ( ) Deceased
Father: Age: ________ ( ) Living ( ) Deceased
Siblings: Age: ________ ( ) Living ( ) Deceased

Please check each box with the appropriate letter if a family member has (had) the following problems (use M-Mother, F-Father, S-Sibling):

__ Diabetes __Stroke __Heart Failure __Arrhythmia __Heart Attack __Pacemaker
__Bypass __Ulcer __Dialysis __Angioplasty __Murmur __ Reflux
__Angina __Headaches __Leg Swelling __Kidney Stones __Hypertension __Obesity
__Thyroid __Arthritis __Emphysema __Tuberculosis __Hemophilia __Pneumonia
__Cancer – where? __Pass Out __Rheumatic fever __Diverticulosis __Hemorrhoids
______________________ __Varicose Veins __Impotence __Cholesterol __Asthma
______________________ __Other ___________________________ __Allergies ________________
__Surgeries ____

CURRENT MEDICATIONS:

Name of Medicine	Strength	Dosage

List of known ALLERGIES: ____

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( ) Tobacco ( ) Type: ________________
( ) Year begun: ___________
( ) Still smoking
( ) Year quit: _____________
( ) Packs per day: _________

( ) Alcohol Type: ____________________
How often: ________________
How much: ________________
How many years: ___________

( ) Exercise ( ) None ( ) light ( ) Moderate ( ) Heavy

Other:____
____
____
____

REVIEW OF SYSTEMS: Do you have (had) the following?:
Check the appropriate box(s)

GENERAL:	□ Weight gain	□ Weight loss	□ Fever	□ Hair loss
	□ Weakness	□ Other: ______________________		
EYES:	□ Eye strain	□ Wear glasses or contact lenses		□ Sensitivity to light
EAR, NOSE,THROAT	□ Ringing in ears	□ Hearing loss	□ Discharge or pain	□ Dizziness
	□ Runny nose	□ Difficulty breathing through nose		□ Sinusitis
	□ Painful teeth, gums, or palate		□ Growths in the mouth	
	□ Pain or difficulty swallowing		□ Hoarseness	
CARDIOVASCULAR	□ Palpitations	□ Chest pain	□ Fainting	□ Dizziness
	□ Varicose veins	□ Difficulty climbing Stairs		□ Pain in the legs
	□ Cold Feet/Hands		□ Shortness of breath	
RESPIRATORY	□ Shortness of breath while walking		□ Cough with or without phlegm	
	□ Asthma/Wheezing		□ Spit up blood	
	□ Other: ______________________			
GASTROINTESTINAL	□ Abdominal pain	□ Nausea	□ Vomiting	□ Diarrhea
	□ Hemorrhoids	□ Change in shape or color of stool		
GENITOURINARY	□ Discharge	□ Pain	□ Frequent urination	□ Pain with urination
MUSCULOSKELETAL	□ Weakness	□ Back Pain	□ Neck Pain	□ Leg Pain
	□ Arm Pain	□ Shoulder Pain	□ Numbness	□ Headaches
	□ Other: ______________________			
SKIN	□ Jaundice	□ Dry skin	□ Pigment Change	□ Growths
	□ Moles that have changed color, shape, or bleed			
NEUROLOGIC	□Tremors	□ Weakness	□ Numbness	□ Memory Loss
	□ Confusion	□ Other: ______________________		