Case History Today's Date: _____

Patient Name:_____ Gender ❑ M ❑ F
Last First Middle

Date of Birth_____/_____/_____ Social Security Number_____-_____-_____ Marital Status:❑S ❑M ❑D ❑W

Address:_____ City_____ State_____ Zip Code_____

Phone (Home)_____ Cell_____ Email_____

Would you like us to send you appointment reminder texts? If so please mark your cell phone carrier:
❑ Sprint/Nextel ❑ AT&T ❑ T-Mobile ❑ Verizon ❑ Other

Occupational Employer_____ Position_____

Emergency Contact: _____ Phone:_____

Health Report

Reason for seeking care:_____

Names of Health Care Providers from whom you are currently receiving care (or have seen in the past 12 months):

_____

Please list all the medications you are taking. Including over the counter medications, herbs & vitamins:

Medication Name	Dose	Medication Name	Dose

Please list all surgical procedures you have had. Please include surgeon and date of procedure:

_____ _____

_____ _____

_____ _____

_____ _____

Do you have a history of smoking? ❑ Yes ❑No If yes, _____# packs per day x _____ for # years
Have you ever chewed tobacco? ❑ Yes ❑No
Have you quit? If so when ❑ Yes ❑No _____
Have you tried quitting? ❑ Yes ❑No If yes what is longest time period you quit smoking?_____

Do you have a history of alcohol use? ❑ Yes ❑No If yes, specify_____ # drinks per ❑ Day ❑ Week
1 "drink" is equal to 12 oz can of beet, 1.5 oz liquor or 5 oz wine

Do you drink caffeinated beverages? ❑ Yes ❑No Amount: ❑ < 3 drinks/day ❑ 3-6 drinks/day ❑ >6 drinks/day
(Including coffee, pop, energy drinks)

Do you use drugs for recreational purposes? ❑ Yes ❑No
If yes, check all that apply ❑ Amphetamines ❑Cocaine ❑Marijuana ❑ Heroin ❑Inhalants ❑LSD

Do you exercise? ❑ Yes ❑No If yes, describe how long and how often you exercise on average week

_____

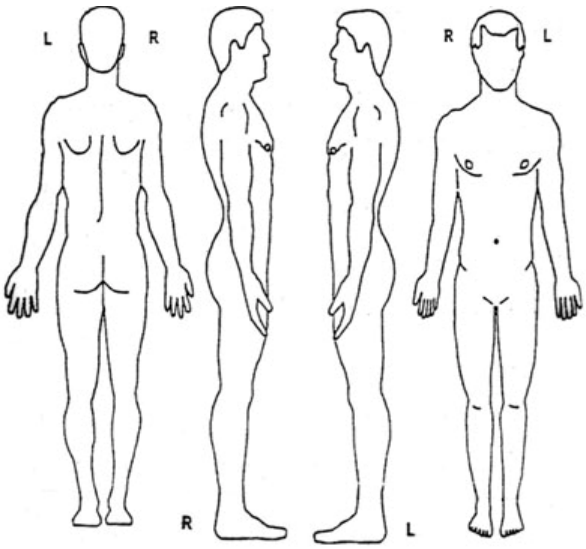
Family Medical History: Please list all known medical problems in your immediate family, age of death and cause.
(Specify M=Mother F=Father B=Brother S=Sister GM=Grandmother GF=Grandfather)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Pain Diagram



Please circle the degree of pain, 0 is none and 10 severe pain
0 1 2 3 4 5 6 7 8 9 10

Mark the picture, using these symbols where you feel pain
Numbness = = =
Dull Ache O O O
Burning XXX
Sharp/Stabbing / / /
Pins, Needles + + +

What aggravates condition or pain:
❑ Walking ❑ Sitting ❑Driving ❑Lifting Working ❑ Standing
❑Sleeping ❑ Other_____

What lessens the pain?_____

What does your condition interfere with? ❑ Work ❑ Sleep ❑Routine

Past Medical History-Please check all that apply

Adrenal Dysfunction	❑ Yes ❑No	Fibromyalgia	❑ Yes ❑No
Alzheimer	❑ Yes ❑No	GERD	❑ Yes ❑No
Anxiety Disorder	❑ Yes ❑No	Glaucoma	❑ Yes ❑No
Arteriovenous Malformation	❑ Yes ❑No	Heart or Valve Defects	❑ Yes ❑No
Arthritis	❑ Yes ❑No	Hepatitis	❑ Yes ❑No
Asthma	❑ Yes ❑No	HIV/AIDS	❑ Yes ❑No
Autoimmune Disease	❑ Yes ❑No	Hypertension	❑ Yes ❑No
Bipolar Disorder	❑ Yes ❑No	Hyperthyroidism	❑ Yes ❑No
Bleeding Disorder	❑ Yes ❑No	Hypothyroidism	❑ Yes ❑No
Claudication	❑ Yes ❑No	Inflammatory Bowel Disease	❑ Yes ❑No
Congenital Heart Defects	❑ Yes ❑No	Malignancy *If yes describe below*	
Coronary Heart Disease	❑ Yes ❑No	Muscular Dystrophy	❑ Yes ❑No
COPD	❑ Yes ❑No	Myocardial Infarction (Heart Attack)	❑ Yes ❑No
Cystic Fibrosis	❑ Yes ❑No	Obstructive Sleep Apnea	❑ Yes ❑No
Depression	❑ Yes ❑No	Osteoporosis	❑ Yes ❑No
Diabetes	❑ Yes ❑No	Peripheral Artery Disease	❑ Yes ❑No
Eclampsia or Preeclampsia	❑ Yes ❑No	Recurrent Infections	❑ Yes ❑No
Endocarditis	❑ Yes ❑No	Restless Leg Syndrome	❑ Yes ❑No
Endometriosis	❑ Yes ❑No	Schizophrenia	❑ Yes ❑No
End Stage Renal Disease	❑ Yes ❑No	Scleroderma	❑ Yes ❑No
		Seizure Disorder	❑ Yes ❑No
		Vaculitis	❑ Yes ❑No
		Visual Defects	❑ Yes ❑No

Review of Systems In the last 6 months, have you experienced any of the following symptoms?

Constitutional

Weight loss of gain	❑ Yes ❑No
Appetite changes	❑ Yes ❑No
Fatigue	❑ Yes ❑No
Fever	❑ Yes ❑No

Eyes

Eye pain or drainage	❑ Yes ❑No
Visual Changes	❑ Yes ❑No
Dry, irritated eyes	❑ Yes ❑No

ENT/Mouth

Ear pain or drainage	❑ Yes ❑No
Frequent sinus infections	❑ Yes ❑No
Hearing changes or loss	❑ Yes ❑No
Nosebleeds	❑ Yes ❑No
Dizziness	❑ Yes ❑No

Respiratory

Genitourinary

Blood in your urine	❑ Yes ❑No
Menstrual changes	❑ Yes ❑No
Urinating that is painful or difficult	❑ Yes ❑No
Erection Problems	❑ Yes ❑No
Vaginal discharge or bleeding	❑ Yes ❑No

Musculoskeletal

Broken Bones	❑ Yes ❑No
Joint pain or swelling	❑ Yes ❑No
Muscle aches	❑ Yes ❑No
Muscle weakness	❑ Yes ❑No
Back pain	❑ Yes ❑No

Neurological

Seizures	❑ Yes ❑No
Coughing or choking with swallowing	❑ Yes ❑No
Extremity pain or burning sensation	❑ Yes ❑No
Numbness or tingling	❑ Yes ❑No

Blood in your sputum ❑ Yes ❑No

Chest Tightness ❑ Yes ❑No
Cough lasting > 1month, productive or not ❑ Yes ❑No
Shortness of breath ❑ Yes ❑No
Wheezing ❑ Yes ❑No
Chest pain with inhalation ❑ Yes ❑No

Cardiovascular
Chest pain or heaviness ❑ Yes ❑No
Palpitations ❑ Yes ❑No
Fainting or near fainting spells ❑ Yes ❑No
Swelling of feet of legs ❑ Yes ❑No
Shortness of breath while lying flat ❑ Yes ❑No

Gastrointestinal
Abdominal pain ❑ Yes ❑No
Blood in your stool ❑ Yes ❑No
Constipation ❑ Yes ❑No
Diarrhea or Food Intolerance ❑ Yes ❑No
Heartburn or Indigestion ❑ Yes ❑No
Vomiting or nausea lasting for >1 day ❑ Yes ❑No
Swallowing difficulty ❑ Yes ❑No

Psych
Anxiety without clear explanation ❑ Yes ❑No
Sadness lasting for days or weeks ❑ Yes ❑No
Hearing voices ❑ Yes ❑No
Thoughts of hurting yourself ❑ Yes ❑No
Thoughts of hurting others ❑ Yes ❑No
Fear of people places or things ❑ Yes ❑No

Difficulty falling asleep or staying asleep ❑ Yes ❑No

Endocrinology
Hair loss ❑ Yes ❑No
Frequent urination ❑ Yes ❑No
Increased thirst ❑ Yes ❑No
Heat or cold intolerance ❑ Yes ❑No

Heme/Lymph
Bleeding from gums or nose ❑ Yes ❑No
Unexplained bruising ❑ Yes ❑No
Night sweats ❑ Yes ❑No
Swollen painful lymph nodes ❑ Yes ❑No

Allergy/Immune
Watery eyes ❑ Yes ❑No
Runny nose ❑ Yes ❑No
Food intolerance ❑ Yes ❑No
Frequent skin sores ❑ Yes ❑No