

NAME: _____

DATE: _____

BIRTHDATE: _____

AGE: _____

HEIGHT: _____ WEIGHT: _____

HOW DID YOU HEAR ABOUT US? _____

EXPLAIN BRIEFLY WHAT BRINGS YOU TO OUR OFFICE: _____

I. PAST MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY):

- | | | |
|---|--|--|
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> GONORRHEA | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> ANGINA PECTORIS | <input type="checkbox"/> GOUT | <input type="checkbox"/> PAGET'S DISEASE |
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> HAY FEVER | <input type="checkbox"/> PANCREATITIS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> PARASITES |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEART MURMURS | <input type="checkbox"/> PERICARDITIS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> PLEURISY |
| <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> PNEUMONIA |
| <input type="checkbox"/> CHRONIC BRONCHITIS | <input type="checkbox"/> HIGH CHOLESTRAL | <input type="checkbox"/> POLIO |
| <input type="checkbox"/> CIRRHOSIS | <input type="checkbox"/> HIGH TRIGLYCERIDES | <input type="checkbox"/> PSYCHIATRIC ILLNESS |
| <input type="checkbox"/> CROHN'S DISEASE | <input type="checkbox"/> HIGH URIC ACID | <input type="checkbox"/> RHEUMATISM |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> HIV POSITIVE(AIDS) | <input type="checkbox"/> SARCOIDOSIS |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> KIDNEY STONES | <input type="checkbox"/> SEIZURES/EPILEPSY |
| <input type="checkbox"/> DIPHTHERIA | <input type="checkbox"/> MEASLES | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> DRUG ADDICTION | <input type="checkbox"/> MENINGITIS | <input type="checkbox"/> SYPHILIS |
| <input type="checkbox"/> DUODENAL ULCER | <input type="checkbox"/> MIGRAINES HEADACHES | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> MUMPS | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> FIBROMYALGIA | <input type="checkbox"/> NEPHRITIS | (OR POSTIVE TEST) |
| <input type="checkbox"/> GALLBLADDER PROBLEMS | <input type="checkbox"/> OSTEOARTHRITIS | <input type="checkbox"/> ULCERATIVE COLITIS |
| <input type="checkbox"/> GASTRIC ULCER | <input type="checkbox"/> OSTEOPENIA | <input type="checkbox"/> VALLEY FEVER |

II. PLEASE LIST ANY HOSPITALIZATION, ILLNESSES, OPERATIONS OR SEVERE INJURIES AND BROKEN BONES:

<u>CONDITION/OPERATION</u>	<u>DATE</u>	<u>HOSPITAL</u>	<u>DOCTOR</u>
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III. PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

IV. PLEASE LIST ALL MEDICATIONS & REACTIONS THAT YOU ARE ALLERGIC TO:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

V. PLEASE LIST ANY ALLERGIES OTHER THAN DRUG RELATED:

VI. FAMILY HISTORY (PLEASE LIST SIGNIFICANT MEDICAL CONDITIONS):

VII. SOCIAL HISTORY

OCCUPATION _____
HAVE YOU MISSED WORK DUE TO INJURY?

HOURS WORKED PER WEEK _____
YES _____ NO _____

IF YES, PLEASE EXPLAIN: _____

DATE LAST WORKED _____ DATE RETURNED : _____ PART TIME _____ FULL TIME _____
DO YOU EXERCISE REGULARLY? YES _____ NO _____ IF YES, WHAT? HOW OFTEN? _____
DO YOU SMOKE? YES _____ NO _____ IF YES, HOW MANY PER DAY? _____
ALCOHOL USE: [] DAILY [] OCCASIONALLY [] RARELY [] NEVER
MARRIAGE STATUS? _____ CHILDREN? _____

HOBBIES: _____

GENERAL

- FEVER
- SHAKING OR CHILLS
- EXCESSIVE OR UNUSUAL FATIGUE
- RECURRENT INFECTIONS
- SWOLLEN GLANDS
- NERVOUSNESS
- SUICIDAL IDEAS
- DIFFICULTY SLEEPING
- ANY OTHER MEDICAL PROBLEMS

EYES

- IMPAIRED/CHANGED VISION
- DOUBLE VISION EYES
- PERSISTENT DRY
- DO YOU USE ARTIFICIAL TEARS?
- CATARACTS
- GLASSES

EARS

- DEAFNESS
- RINGING IN EARS
- HEARING AID

NOSE

- NOSE BLEEDS
- SINUS TROUBLE

MOUTH

- MOUTH ULCERS
- PERSISTENT DRY MOUTH
- JAW PAIN WITH CHEWING
- EXCESSIVE THIRST

THROAT

- SORE THROATS
- HOARSENESS

SKIN

- RASH
- PSORIASIS
- LUMPS OR NODULES
- SKIN SENSITIVITY
- CHANGE IN SKIN TEXTURE
- EASY BRUISING OR BLEEDING
- SKIN ULCERS
- ABNORMAL HAIR LOSS
- FINGERS TURNING WHITE ON EXPOSURE TO COLD

CARDIO-RESPIRATORY

- SHORTNESS OF BREATH
- CHEST PAIN
- COUGH
- COUGHING UP BLOOD
- PALPITATIONS
- LEG SWELLING

GASTROINTESTINAL

- DIFFICULTY SWALLOWING
- HEARTBURN
- NAUSEA
- VOMITING BLOOD
- ABDOMINAL PAIN
- CONSTIPATION
- DIARRHEA
- STOOL WHICH ARE BLACK AND / OR BLOODY
- RECENT CHANGE IN BOWEL HABITS

GENTOURINARY

- FREQUENCY OF URINATION: _____ TIMES A NIGHT _____
- BURNING WITH URINATION
- URGENCY OF URINATION
- DIFFICULTY STARTING AND STOPPING URINE FLOW
- RASH OR SORES ON GENITALS
- BLOOD IN URINE

METABOLIC

- UNUSUAL HEAT INTOLERANCE
- UNUSUAL COLD INTOLERANCE
- EXCESSIVE APPETITE
- LOSS OF APPETITE
- HOT FLASHES
- WEIGHT LOSS
- WEIGHT GAIN

MUSCULOSKELETAL

- NECK PAIN
- BACK PAIN
 - LOWER [] UPPER
- MUSCLE PAIN OR WEAKNESS
- SWOLLEN JOINTS
 - WHERE? _____
- PAINFUL JOINTS
 - WHERE? _____
- STIFFNESS
 - WHERE? _____

NEUROLOGIC

- HEADACHES
- NUMBNESS
- LOSS OF MEMORY
- LOSS OF CONSCIOUSNESS
- DIZZINESS
- FEELING SAD

WHAT MAKES YOUR PAIN WORSE?

- SITTING
- LYING DOWN
- WALKING
- STANDING

WHAT MAKES IT BETTER?

- REST
- MEDICATION
- EXERCISE
- NOTHING
- PHYSICAL THERAPY
- CHIROPRACTIC