CONFIDENTIAL

PATIENT

HEALTH

RECORD

Personal History

First Name ______________________

Middle Name ______________________

Last Name ______________________

Birthdate ______________________

Social Security Number ______________________

Address ______________________

Address 2 ______________________

City + State + Zip Code ______________________

Home Phone Number ______________________

Cell Phone Number ______________________

Email Address ______________________

Spouse's Name // if applicable ______________________

Mark Applicable divorced . married . single . separated . widowed

Employer Information ______________________________

Business Name ______________________________

Occupation // Job Title ______________________________

Years at Present Job ______________________________

Business Phone Number ______________________________

Emergency Contact ______________________________

Phone Number ______________________________

Relationship ______________________________

How did you hear about our clinic? ______________________________

____

I hereby state the above information is correct and true to the best of my knowledge. I am the responsible party.

Signature of Patient or Guardian ____________________ Date __________

Physician Name ____________________ Date __________

Patient Name ____________________ Birthdate __________

* Please fill out *all* of the following information carefully and thoroughly for our patient health records!

Past, Family, and Social History

Childhood Illness:

- ☐ I deny any childhood illness.
- ☐ ADD
- ☐ allergies // hay fever
- ☐ asthma
- ☐ atopic dermatitis // eczema
- ☐ bedwetting
- ☐ cerebral palsy
- ☐ chicken pox
- ☐ depression
- ☐ diabetes
- ☐ fetal drug exposure
- ☐ food allergies
- ☐ headaches
- ☐ hepatitis
- ☐ HIV
- ☐ measles
- ☐ mumps rash
- ☐ scoliosis
- ☐ seizure disorder
- ☐ sickle cell anemia
- ☐ spina bifida
- ☐ other // please describe below

____

____

____

____

Adult Illness:

- ☐ I deny any adult illness.
- ☐ alzheimer's
- ☐ anemia
- ☐ arthritis
- ☐ asthma
- ☐ cancer
- ☐ Chicken pox
- ☐ CRPS // RSD
- ☐ cystic kidney disease
- ☐ depression
- ☐ diabetes 1
- ☐ diabetes 2
- ☐ emphysema
- ☐ eye problems
- ☐ fibromyalgia
- ☐ heart disease
- ☐ hepatitis
- ☐ HIV
- ☐ hypertension
- ☐ influenza pneumonia
- ☐ liver disease
- ☐ vertigo/dizziness
- ☐ lung disease
- ☐ lupus erythema
- ☐ multiple sclerosis
- ☐ parkinson's
- ☐ pleurisy
- ☐ pneumonia
- ☐ psychiatric
- ☐ scoliosis
- ☐ seizure disorder
- ☐ shingles
- ☐ STD / unspecified
- ☐ stroke / CVA
- ☐ suicide attempt
- ☐ thyroid problems
- ☐ other / please describe below

____

____

____

____

____

Surgeries:

- ☐ I deny any surgeries.
- ☐ angioplasty
- ☐ appendectomy
- ☐ cesarean section
- ☐ cardiac catheterization
- ☐ carpal tunnel repair
- ☐ coronary bypass
- ☐ cosmetic
- ☐ D & C
- ☐ dental surgery
- ☐ gallbladder
- ☐ hemorrhoid removal
- ☐ hernia repair
- ☐ hysterectomy
- ☐ joint reconstruction
- ☐ joint replacement
- ☐ laminectomy
- ☐ mastectomy
- ☐ pacemaker insertion
- ☐ rotator cuff repair
- ☐ spinal fusion
- ☐ tonsillectomy
- ☐ other /please describe below

____

____

____

____

Injuries:

- ☐ I deny any injuries.
- ☐ back injuries
- ☐ broken bones
- ☐ car crash
- ☐ disability
- ☐ fracture
- ☐ head injury
- ☐ industrial accident
- ☐ joint injury
- ☐ mild soft tissue injury
- ☐ severe fall

OB // GYN:

- ☐ I deny any OB/GYN issues.
- ☐ never been pregnant
- ☐ have been pregnant
- ☐ currently pregnant
- ___ # of pregnancies
- ___ # of complicated pregnancies
- ___ # of miscarriages
- ___ # of uncomplicated pregnancies
- ___ # of c-sections
- ___ # of terminated pregnancies
- ___ # of vaginal deliveries
- ___ # of epidural injections

Age of onset menses: ________________________________

my menses is ... ☐ regular ☐ irregular ☐ menopause

Immunization:

- ☐ I deny any immunization.
- ☐ DTAP
- ☐ flu
- ☐ hepatitis A
- ☐ hepatitis C
- ☐ influenza
- ☐ IPV/polio
- ☐ smallpox
- ☐ pneumococcal
- ☐ PPD / mantoux test TB
- ☐ varivax / chicken pox
- ☐ whooping cough / pertussis
- ☐ MMR / measles . mumps . rubella
- ☐ other / please describe below

____

____

____

____

Name of General / Family Doctor ____

Other Medical Providers Seen ____

Currently:

☐ Medications & Their purpose/ please describe below

____

____

____

____

☐ None

▪ ▪ ▪ ▪ ▪ ▪

☐ Vitamins & Herbs // please describe below

____

____

____

____

☐ None

▪ ▪ ▪ ▪ ▪ ▪

☐ Non-Drug Allergies and Symptoms Caused // please describe below

____

____

____

____

☐ None

Social History:

alcohol :

- ☐ never
- ☐ social consumption
- ☐ beer
- ☐ wine

___ glasses per

- ☐ day
- ☐ week
- ☐ month

tobacco :

- ☐ I deny any tobacco use.
- ☐ live with a smoker
- ☐ quit smoking : how long _______________
- ☐ smoke _____ packs // cigarettes per
  - ☐ day
  - ☐ week
- ☐ chewing tobacco : chew cans _____ per
  - ☐ day
  - ☐ week

*cigarettes, pipes, cigars, chew, etc.

Diet // please list your daily intake :

____
____
____
____
____
____
____
____
____

drugs :

- ☐ I deny all illegal and IV drug use.
- ☐ I have not used drugs since _______
- ☐ I have used drugs since _______

Family History

Father ☐ alive ☐ deceased

Has had the following conditions:

____

____

Mother ☐ alive ☐ deceased

Has had the following conditions:

____

____

Paternal Grandfather ☐ alive ☐ deceased

Has had the following conditions:

____

____

Paternal Grandmother ☐ alive ☐ deceased

Has had the following conditions:

____

____

Maternal Grandfather ☐ alive ☐ deceased

Has had the following conditions:

____

____

Maternal Grandmother ◻ alive ◻ deceased

Has had the following conditions:

____

____

Brothers ____ # of brothers ____ ages of brothers ◻ alive ◻ deceased

Has had the following conditions:

____

____

Sisters ____ # of sisters ____ ages of sisters ◻ alive ◻ deceased

Has had the following conditions:

____

____

Sons ____ # of sons ____ ages of sons ◻ alive ◻ deceased

Has had the following conditions:

____

____

Daughters ____ # of daughters ____ ages of daughters ◻ alive ◻ deceased

Has had the following conditions:

____

____

Review of Systems

Below is a list of diseases/conditions that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care. However, if none of the diseases/conditions in a section apply to you, please mark the first option stating that you deny all issues regarding that area.

Eyes / Vision:

- ☐ I deny any eye / vision issues.
- ☐ blindness
- ☐ blurred vision
- ☐ cataracts
- ☐ change in vision
- ☐ double vision
- ☐ eye pain
- ☐ field cuts
- ☐ glaucoma
- ☐ itching / eyes
- ☐ photophobia
- ☐ tearing
- ☐ wears glasses or contacts

Constitution:

- ☐ I deny any constitutional issues.
- ☐ chills
- ☐ daytime somnolence / drowsiness
- ☐ fatigue
- ☐ fever
- ☐ night sweats
- ☐ weight gain
- ☐ weight loss

Ears / Nose / Throat:

- ☐ I deny any ears / nose / throat issues.
- ☐ bleeding
- ☐ dentures
- ☐ difficulty swallowing
- ☐ discharge
- ☐ dizziness
- ☐ ear drainage
- ☐ ear infections
- ☐ ear pain
- ☐ fainting
- ☐ sore throat
- ☐ frequent sore throat
- ☐ headaches
- ☐ head injuries
- ☐ hearing loss
- ☐ hoarseness
- ☐ loss of smell
- ☐ nasal congestion
- ☐ nose bleeds
- ☐ post nasal drip
- ☐ snoring
- ☐ rhinorrhea / runny nose
- ☐ sinus infection
- ☐ TMJ problems
- ☐ tinnitus / ringing in the ears

Respiration:

- ☐ I deny any respiratory issues.
- ☐ asthma
- ☐ cough
- ☐ coughing up blood
- ☐ shortness of breath
- ☐ wheezing
- ☐ sputum production

Cardiovascular:

- ☐ I deny any cardiovascular issues.
- ☐ angina
- ☐ chest pain
- ☐ claudication / leg pain or aches
- ☐ heart murmur
- ☐ heart problems
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ orthopnea
- ☐ varicose veins
- ☐ ulcers
- ☐ shortness of breath
- ☐ swelling of legs
- ☐ paroxysmal nocturnal dyspnea
- ☐ palpitations / irregular heart beat

Male:

- ☐ I deny any male issues.
- ☐ burning urination
- ☐ erectile dysfunction
- ☐ frequent urination
- ☐ hesitancy / dribbling
- ☐ prostate problems
- ☐ urine retention

Skin:

- ☐ I deny any skin issues.
- ☐ changes in nail texture
- ☐ changes in skin color
- ☐ hair growth
- ☐ hair loss
- ☐ hives
- ☐ itching
- ☐ paresthesia / numbness, tingling
- ☐ rash
- ☐ history of skin disorder
- ☐ skin lesions / ulcers
- ☐ varicosities

Female:

- ☐ I deny any female issues.
- ☐ birth control therapy
- ☐ breast lumps/pain
- ☐ burning urination
- ☐ cramps
- ☐ frequent urination
- ☐ hormone therapy
- ☐ irregular menstruation
- ☐ urine retention
- ☐ vaginal bleeding
- ☐ vaginal discharge

Gastrointestinal:

- ☐ I deny any gastrointestinal issues.
- ☐ abdominal pain
- ☐ belching
- ☐ black tarry stools
- ☐ constipation
- ☐ diarrhea
- ☐ difficulty swallowing
- ☐ heartburn
- ☐ hemorrhoids
- ☐ indigestion
- ☐ jaundice
- ☐ nausea
- ☐ rectal bleeding
- ☐ vomiting
- ☐ vomiting blood
- ☐ abnormal stool quality
- ☐ abnormal stool color
- ☐ abnormal stool consistency

Endocrine:

- ☐ I deny any endocrine issues.
- ☐ cold intolerance
- ☐ diabetes
- ☐ excessive appetite
- ☐ excessive hunger
- ☐ excessive thirst
- ☐ frequent urination
- ☐ goiter
- ☐ hair loss
- ☐ heat intolerance
- ☐ unusual hair growth
- ☐ voice changes

Nervous System:

- ☐ I deny nervous system issues.
- ☐ dizziness
- ☐ facial weakness
- ☐ headaches
- ☐ limb weakness
- ☐ loss of consciousness
- ☐ loss of memory
- ☐ numbness
- ☐ seizures
- ☐ sleep disturbance
- ☐ slurred speech
- ☐ stress
- ☐ strokes
- ☐ tremors
- ☐ unsteadiness of gait

Psychological:

- ☐ I deny any psychological issues.
- ☐ anhedonia // inability to experience joy
- ☐ anxiety
- ☐ appetite changes
- ☐ behavioral changes
- ☐ bipolar disorder
- ☐ confusion
- ☐ convulsions
- ☐ depression
- ☐ insomnia
- ☐ memory loss
- ☐ mood changes
- ☐ other / please describe below

____

____

Hematology:

- ☐ I deny any hematology issues.
- ☐ anemia
- ☐ blood clotting
- ☐ bleeding
- ☐ blood transfusion
- ☐ bruises easily
- ☐ fatigue
- ☐ lymph node swelling

Allergy:

- ☐ I deny any allergy issues.
- ☐ anaphylaxis / history of
- ☐ food intolerance
- ☐ itching
- ☐ nasal congestion
- ☐ rash
- ☐ sneezing

Your Current Health Condition

Do you have any complaints with your head or in your neck region? ◻ Yes ◻ No

Is this a new condition, recurring condition, aggravation of an old condition, or a chronic condition?

____

When did the condition start or become aggravated / specific date or # of days, months, etc.?

____

What caused the condition / car accident, slip, fall, sports injury, etc.?

____

Which of these describes your current symptoms?

◻ pain ◻ numbness ◻ stiffness ◻ weakness

In what location are you feeling these symptoms?

____

When are symptoms present? ◻ constantly ◻ off and on throughout the day

When are symptoms worse? ◻ morning ◻afternoon ◻evening ◻with activity

Do the symptoms cause?

◻ headaches ◻ blurred vision ◻dizziness ◻nausea ◻ringing in the ears

◻ irritability / mood swings ◻ other symptoms currently experiencing:

____

Do you have any complaints with your upper, mid, or lower back region? ☐ Yes ☐ No

Is this a new or recurring condition or an aggravation of an old condition, or a chronic condition?

When did the condition start or become aggravated / specific date or # of days, months, etc.?

What caused the condition / car accident, slip, fall, sports injury, etc.?

Which of these describe your current symptoms?

☐ pain ☐ numbness ☐ stiffness ☐ weakness

In what location are you feeling these symptoms?

When are symptoms present? ☐ constantly ☐ off and on throughout the day

When are symptoms worse? ☐ morning ☐afternoon ☐evening ☐with activity

When do you experience the symptoms?

☐ headaches ☐ blurred vision ☐dizziness ☐nausea ☐ringing in the ears

☐ irritability / mood swings ☐ other symptoms currently experiencing:

Do you have any complaints with your shoulders, arms, legs, knees, feet, etc.? ◻ Yes ◻ No

____

In general, do you feel any of the following qualities of pain?

◻ burning ◻ diffuse ◻ dull / achy ◻ localized ◻ radiating ◻ sharp ◻ shooting

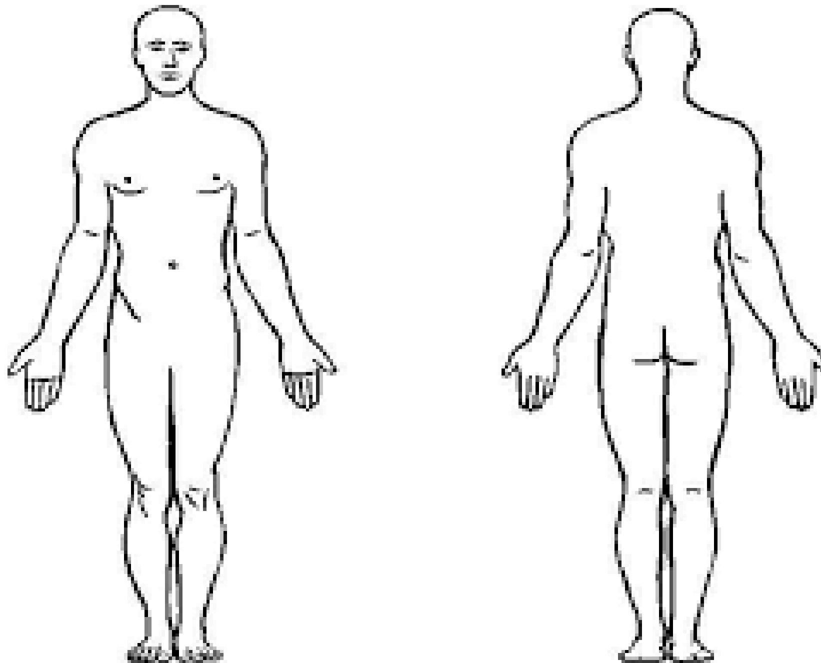
◻ stabbing ◻ tingling ◻ throbbing ◻ tightness ◻ other: ______________________

V.A.S. Rating / please grade on the scale below your present symptoms at rest and during activity:

At Rest: pain free 1 2 3 4 5 6 7 8 9 10 extreme pain

Active: pain free 1 2 3 4 5 6 7 8 9 10 extreme pain

Please mark all of your pain qualities on the bodies below.



Activities of Daily Living

Below is a list of many common daily activities. Please indicate on the chart whether the pain or discomfort you feel has no effect, a mildly limiting effect, a moderately limiting effect, or a severely limiting effect on your ability to perform that daily activity.

	no pain	mild pain	moderate pain	severe pain
bending	☐	☐	☐	☐
caring for family	☐	☐	☐	☐
carrying objects	☐	☐	☐	☐
change position	☐	☐	☐	☐
climbing stairs	☐	☐	☐	☐
driving	☐	☐	☐	☐
extended computer use	☐	☐	☐	☐
eating	☐	☐	☐	☐
household cleaning	☐	☐	☐	☐
kneeling	☐	☐	☐	☐
lifting children	☐	☐	☐	☐
pet care	☐	☐	☐	☐
reading / concentration	☐	☐	☐	☐
self-care / dressing	☐	☐	☐	☐
self-care / shaving	☐	☐	☐	☐
sexual activity	☐	☐	☐	☐

Activities of Daily Living Continued

	no pain	mild pain	moderate pain	severe pain
sleep	☐	☐	☐	☐
static sitting	☐	☐	☐	☐
static standing	☐	☐	☐	☐
walking	☐	☐	☐	☐
yard work	☐	☐	☐	☐
work activities	☐	☐	☐	☐
______________________________*	☐	☐	☐	☐
______________________________*	☐	☐	☐	☐

* Please name any other recreational activities that cause an increase of symptoms or pain.
example// bike riding, playing baseball, cooking, gardening, swimming, etc.