PATIENT HISTORY

General Health Review

Date: _____ Patient Name: _____

TELL US ABOUT YOURSELF AND YOUR PAST MEDICAL HISTORY:

Circle anything listed below to which you are allergic:

(A) No known allergies
(8) Penicillin
(C) Tetracycline
(0) Sulfa
(E) Morphine
(F) Morphine
(F) Erythromycin
(G) Dust Cephalosporins
(H) Codeine
(I) lodine/8etadine
(J) Radiographic Dyes
(K) Adhesive Tape
(L) Paint
(M) Other (Specify): _____

Circle any of the medical problems listed below that you have now or have had in the past (if in the past and do not presently have mark with an*):

(A) I have no known medical problems
(8) Hypertension
(C) Coronary artery disease
(D) Peripheral vascular disease
(E) Adult onset diabetes
(F) Childhood onset *diabetes*
(G) Past heart attack
(H) Asthma
(I) Cancer
(J) Ulcers
(K) Hepatitis (A / 8 / C)
(L) Tuberculosis
(M) Liver disease
(N) Seizure disorder
(0) Thyroid disease
(P) Emphysema
(Q) COPD/Lung Problem
(R) Immune disorder
(S) Overweight
(T Osteomyelitis
(U) Blood Clot (DVT)
(V) High Cholesterol
(W) Depression
(X) Anxiety
(Y) Headaches
(Z) Kidney disease
(AA) Rheumatoid Arthritis
(BB) Osteoarthritis
(CC) Circulation problems
(DD) Eye Problems
(EE) Ear Problems
(FF) Other (Specify): _____

Intolerances (include side effects from previous medications, such as gastritis, nausea, constipation etc.)

If you take pain medication, do you take it only when needed or regularly by the clock?

Are you taking blood thinners, e.g., Coumadin, Heparin? _____

CURRENT MEDICATIONS

A. None
B. Yes: Please list below

Name	Dose (How many times a day)	For what problem?

Circle any surgeries listed below you may have had. Indicate the year of the surgery:

(A) No previous surgeries
(B) Appendectomy
(C) Cataract extraction
(D) By-pass / open heart
(E) Gall bladder
(F) Hernia repair
(G) Hysterectomy _____
(H) Lumber laminectomy _____
(I) Mastetomy _____ _
(J) Tonsillectomy _____ _
(K) Prostate surgery _____ _
(L) Other (Specify): _____ _

How much alcohol do you consume in an average week (beer, wine, etc.)?

(A) None
(B) Less than 6 drinks
(C) 6-12 drinks
(D) 12-24 drinks
(E) 24-48 drinks
(F) More than 48 drinks

Do you now, or have you ever smoked cigarettes?

(A) Yes, I am currently a smoker
I smoke (circle one) 1 2 3 __ _____packs/day
I have smoked for years

(B) No, but I used to smoke I smoked for _____ _____ years
When did you stop smoking _____

(C) No, I have never smoked

(D) Do you smoke a pipe

(E) Do you smoke Cigars

Which of the following drugs or substances, if any, have you used in the past? (Circle all that apply) next to each drug or substance that you've circled, indicate if you used it occasionally ("a"), frequently ("F"), or continuously ("C")

Alcohol
Heroin
Other (specify)

Barbiturates _____
Amphetamines _____
Other _____ (specify)

Cocaine _____ _
Marijuana _____ _
Other _____ _ (specify)

Are you presently using any of the drugs or substances below? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you use it occasionally ("a", frequently ("F"), or continuously ("C")

Alcohol
Heroin
Other (specify)

Barbiturates _____
Amphetamines _____
Other _____ (specify)

Cocaine _____
Marijuana _____
Other _____ (specify)

Has anyone in your immediate family ever had any of the following? Circle the illnesses that apply

(A) None known
(B) Cancer
(C) Leukemia
(D) Stroke
(E) Hypertension
(F) Coronary artery disease
(G) Rheumatic fever
(H) Diabetes
(I) Hypothyroidism
(J) Colitis
(K) Bleeding Tendency
(L) Asthma
(M) Tuberculosis
(N) Seizure Disorder
(0) Alcoholism
(P) Scoliosis
(0) Back or Neck problems
(R) Osteoarthritis or Rheumatoid arthritis
(S) Other (Specify): _____ _

Have you ever had a blood clot? Yes No

Do you have any of the following? (Circle all that apply)

Headaches
Vision Problems
Hearing Problems
Dizziness
Difficulty Swallowing
Chronic Fatigue
Stomach Pain
Nausea
Vomiting
Constipation
Diarrhea
Chest Pain
Shortness of Breath
Urinary Problems
Rashes
Swollen Joints

Do you have any of the following presently? (Circle all that apply)

High Blood Pressure
Chronic Cough
Liver Disease
Seizure Disorder
Heart Problems
Bleeding Problems
Ulcers
Cancer
Asthma
Kidney Disease
Diabetes

DOMESTIC SITUATION

With whom do you live? _____

Are there any substance abuse issues in the household? Yes_____ No ____

If yes, please explain _____

Are you able to take care of yourself? Yes___ No___

If not, please enter name of caregiver? _____

Are you married, single, divorced, or widowed? _____

Have any family members ever had a chronic pain problem? _____

If yes, give details. _____

What is your current work status?

A. Regular employment - no restrictions
B. Full time with restrictions
C. Part time by choice
D. Part time with restrictions
E. Part time due to medical reason, Specify _____
F. Retired by choice
G. Retired due to other medical reason, Specify _____
H. Umemployed
I. Currently not working due to medical reason, Specify _____ _
J. Student

LEGAL MATTERS

Are you presently involved in a lawsuit? Yes__ No__ If yes, please explain.

Is this a workman's compensation case? Yes Yes __