Initial Confidential Patient Case History

Name:_____ DOB: _____ M S D W (Circle One)
Street Address:_____ City: _____ State: _____ Zip: _____
Driver's License #_____ Social Security # _____ Sex: M F (Circle One)
Cell Phone: _____ Home Phone: _____ Email: _____
Work Phone: _____ Business Employer: _____
Emergency Contact: _____ Phone: _____ Relationship: _____

Please check the appropriate box for any of the following symptoms that you now have or have had previously. Leave blank any that do not apply. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – Occasional **F** – Frequent **C**- Constant (if it does not apply, leave unchecked)

O	F	C	
			GENERAL
☐	☐	☐	Allergies
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
			MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
			Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Sciatica

O	F	C	
			GASTRO-INTESTINAL
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
			EYES, EARS, NOSE &THROAT
☐	☐	☐	Asthma
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Sinus infection
			GENITO-URINARY
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination

O	F	C	
			CARDIO-VASCULAR
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
			RESPIRATORY
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing
			SKIN
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins
			FOR WOMEN ONLY
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge
☐ Yes ☐ No Are you pregnant?			

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism	☐ Diabetes	☐ Hepatitis	☐ Multiple sclerosis	☐ Stroke
☐ Anemia	☐ Diphtheria	☐ HIV	☐ Mumps	☐ Tuberculosis
☐ Anorexia	☐ Drug Abuse	☐ Hypoglycemia	☐ Pleurisy	☐ Typhoid fever
☐ Appendicitis	☐ Eczema	☐ Influenza	☐ Pneumonia	☐ Ulcers
☐ Arteriosclerosis	☐ Emphysema	☐ Lyme Disease	☐ Polio	☐ Venereal disease
☐ Bulimia	☐ Epilepsy	☐ Lumbago	☐ Psychiatric Disorder	☐ Whooping cough
☐ Candidacies	☐ Fever Blisters	☐ Malaria	☐ Rheumatic Fever	
☐ Cold sores	☐ Goiter	☐ Measles	☐ Recreational Drugs	
☐ Depression	☐ Gout	☐ Miscarriage	☐ Scarlet fever	

Cancer: Y N Heart Disease: Y N Kidney Disease: Y N
Respiratory Illness: Y N Polycystic Ovarian Syndrome: Y N Seizures: Y N

If you have answered YES to any of the above conditions, please explain: _____

_____

_____

Have you ever been hospitalized or under medical care for any operation/psychiatric care/alcohol or drug rehab? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

ALLERGIES/INTOLERANCES

☐ None ☐ X-Ray Dye ☐ Sulfa ☐ Pollen ☐ Food ☐ Soaps/Lotions ☐ Environment ☐ Adhesives ☐ Medication ☐ Other: (List Substance and Reaction) : _____

_____

_____

What is your major complaint?

_____

_____

List surgical operation and years:

_____

_____

_____

Current Medications: Prescriptions Only

Medication/Dose/How often	Reason for Taking	Prescribing M.D.