

## CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records.  
THANK YOU.

Name \_\_\_\_\_ Birthday \_\_\_\_\_ Sex  M  F

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ E-Mail \_\_\_\_\_

Marital Status:  M  D  S  W Children, Ages \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Who referred you to us? \_\_\_\_\_ How else did you hear about us? \_\_\_\_\_

What is your major complaint?

\_\_\_\_\_  
\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Have you had this or similar conditions in the past? \_\_\_\_\_

Do any positions make it feel worse? \_\_\_\_\_

Do any positions make it feel better? \_\_\_\_\_

Is this condition:  Improved  Unchanged  Getting Worse

Is this condition interfering with your:  Work  Sleep  Daily Routine Other \_\_\_\_\_

Other doctors or therapist who have treated THIS condition \_\_\_\_\_

What do you think caused this condition? \_\_\_\_\_

List surgical operations and years:

\_\_\_\_\_  
\_\_\_\_\_

Do you have a family physician? Name \_\_\_\_\_

Medications, dosage and frequency:

\_\_\_\_\_  
\_\_\_\_\_

Have you been in an auto accident or had any other personal injury?  Y  N Describe

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**REVIEW OF SYSTEMS** Check only the ones you now have or have had in the past.

<u>GENERAL</u>	NOW	PAST	<u>THROAT</u>	NOW	PAST	<u>GASTROINTESTINAL</u>	NOW	PAST
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
<u>SKIN</u>			<u>NECK</u>			Irregular Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Masses	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>	<u>BREASTS</u>			Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
<u>HEAD</u>			Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<u>GENITOURINARY</u>		
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Bumps	<input type="checkbox"/>	<input type="checkbox"/>	Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Last Eye Exam			Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>	Straining	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>	<u>LUNGS</u>			Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stones	<input type="checkbox"/>	<input type="checkbox"/>
<u>EARS</u>			Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Small Stream	<input type="checkbox"/>	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<u>HEART</u>			Urine Color _____		
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Spotting Between		
<u>NOSE</u>			Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Periods	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>	Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Contraception Type _____		
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<u>BLOOD</u>			Age at First Period _____		
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Cycle _____		
<u>MOUTH</u>			Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Flow _____		
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	No. of Pregnancies _____		
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	No. of Births _____		
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>	No. of Miscarriages _____		
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>	No. of Abortions _____		
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Sugar in Blood	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Flow <input type="checkbox"/> Heavy <input type="checkbox"/> Mod <input type="checkbox"/> Light		
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Red Spots	<input type="checkbox"/>	<input type="checkbox"/>	Last Period _____		
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>				Last Pap Smear _____		
Blisters	<input type="checkbox"/>	<input type="checkbox"/>				Last Vaginal Exam _____		
						Last Mammogram _____		
						Last Prostate Exam _____		

NAME \_\_\_\_\_

**NEUROLOGIC**    NOW    PAST

- Seizures     N     P
- Vertigo     N     P
- Dizziness     N     P
- Hand Trembling     N     P
- Loss of Sensation     N     P
- Incoordination     N     P
- Loss of Facial     N     P
- Weak Grip     N     P
- Paralysis     N     P
- Difficulty Speech     N     P
- Tingling     N     P
- Loss of Memory     N     P
- Numbness     N     P

**ENDOCRINE**

- Weight Loss     N     P
- Weight Gain     N     P
- Extremely Thin     N     P
- Heat Intolerance     N     P
- Cold Intolerance     N     P
- Hair Changes     N     P
- Breast Changes     N     P

**IMMUNIZATION/VACCINATION**

- DPT    Y
- Mumps    Y
- Smallpox    Y
- Typhoid    Y
- Tetanus    Y
- Measles    Y
- Pneumococcal    Y
- Influenza    Y
- Polio    Y
- MMR    Y

**BLOOD TYPE**

- A +     A -
- B +     B -
- AB +     AB -
- O +     O -
- Other \_\_\_\_\_

**BLOOD TRANSFUSIONS**

- Date \_\_\_\_\_
- Date \_\_\_\_\_
- Date \_\_\_\_\_
- Date \_\_\_\_\_

**PSYCHIATRIC**    NOW    PAST

- Hyperventilation     N     P
- Insecurity     N     P
- Depression     N     P
- Troubled Sleep     N     P
- Irritable     N     P
- Undecidedness     N     P
- Timid     N     P
- Hallucinations     N     P
- Loss of Memory     N     P
- Alcoholism     N     P
- Drug Addiction     N     P
- Drug Dependent     N     P
- Suicidal Thoughts     N     P
- Extreme Worry     N     P
- Sexual Problems     N     P

**PAST MEDICAL HISTORY. Check only the ones you have had in the past.**

- |   |   |
|---|---|
| Hay Fever    Y <input type="checkbox"/>       | Parasites    Y <input type="checkbox"/>         |
| Mumps    Y <input type="checkbox"/>           | Epilepsy    Y <input type="checkbox"/>          |
| Rheumatic Fever    Y <input type="checkbox"/> | Paralysis    Y <input type="checkbox"/>         |
| Allergies    Y <input type="checkbox"/>       | Polio    Y <input type="checkbox"/>             |
| Angina    Y <input type="checkbox"/>          | Mental Illness    Y <input type="checkbox"/>    |
| Cancer    Y <input type="checkbox"/>          | Alcoholism    Y <input type="checkbox"/>        |
| Tumor    Y <input type="checkbox"/>           | Depression    Y <input type="checkbox"/>        |
| Blood Disease    Y <input type="checkbox"/>   | Nervous Breakdown    Y <input type="checkbox"/> |
| Leukemia    Y <input type="checkbox"/>        | Migraine    Y <input type="checkbox"/>          |
| Heart Trouble    Y <input type="checkbox"/>   | Gout    Y <input type="checkbox"/>              |
| Varicose Veins    Y <input type="checkbox"/>  | Hemorrhoids    Y <input type="checkbox"/>       |
| Phlebitis    Y <input type="checkbox"/>       | Prostate Problems    Y <input type="checkbox"/> |
| Hypertension    Y <input type="checkbox"/>    | Sexual Problems    Y <input type="checkbox"/>   |
| Stroke    Y <input type="checkbox"/>          | Gonorrhea    Y <input type="checkbox"/>         |
| Ulcers    Y <input type="checkbox"/>          | Syphilis    Y <input type="checkbox"/>          |
| Jaundice    Y <input type="checkbox"/>        | Diabetes    Y <input type="checkbox"/>          |
| Skin Trouble    Y <input type="checkbox"/>    | Bladder Trouble    Y <input type="checkbox"/>   |
| Gallstones    Y <input type="checkbox"/>      | Kidney Stones    Y <input type="checkbox"/>     |
| Liver Trouble    Y <input type="checkbox"/>   | Kidney Infections    Y <input type="checkbox"/> |
| Hepatitis    Y <input type="checkbox"/>       | Dysentery    Y <input type="checkbox"/>         |

**MUSCULOSKELETAL**    NOW    PAST

- Muscle Pain     N     P
- Muscle Weakness     N     P
- Muscle Cramps     N     P
- Muscle Twitching     N     P
- Joint Stiffness     N     P
- Joint Pain     N     P

Date of Last Chest X-Ray \_\_\_\_\_  Normal     Abnormal

Last TB Skin Test \_\_\_\_\_  Normal     Abnormal

Allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY** List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

**SOCIAL HISTORY** Check the boxes and fill in.

Current Weight \_\_\_\_\_ Have you recently lost or gained weight? \_\_\_\_\_ Height \_\_\_\_\_

Mental Work  Heavy  Moderate  Light Hours per day \_\_\_\_\_

Physical Work  Heavy  Moderate  Light Hours per day \_\_\_\_\_

Exercise  Heavy  Moderate  Light Hours per week \_\_\_\_\_ Type \_\_\_\_\_

Smoking  Current  Previous Packs/Day \_\_\_\_\_ No. of years \_\_\_\_\_

Alcohol Beer/Week \_\_\_\_\_ Liquor/Week \_\_\_\_\_ Wine/Week \_\_\_\_\_ No. of Years \_\_\_\_\_

Caffeine (Coffee, Tea, Cola) Cups/Day \_\_\_\_\_ No. of Years \_\_\_\_\_

Aspirin No./Day \_\_\_\_\_ No. of Years \_\_\_\_\_ Others \_\_\_\_\_

**MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT.** Use the following symbols:

Aches ^^^^ Numbness oooo Pins/Needles . . . . Stabbing ////

**MARK AN "X" ON THE LINES:**

How bad are your symptoms now?

-----  
None Most Severe

How bad have they been in the past?

-----  
None Most Severe

