

**MEDICAL HISTORY**

**Date** \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

In order to be able to help with your problem, we need a complete detailed history; please complete this form fully. If you need more space please write on the back of the pages as needed.

Are you RIGHT \_\_\_\_\_ or LEFT \_\_\_\_\_ handed? Height \_\_\_\_\_ Weight \_\_\_\_\_

**Family Doctor:** \_\_\_\_\_ **Referring Doctor:** \_\_\_\_\_

**CHIEF COMPLAINT:** (in a few words summarize your problem): \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS:** (give a detailed account of your problem starting from the onset; describe contributing factors and prior treatment if necessary):

**PAIN ASSESSMENT:** On a scale of 0 to 10 please rate your pain today (with "0" indicating no pain and 10 being the worst pain imaginable) \_\_\_\_\_

**SYSTEM REVIEW:** (problems you have with other body parts or functions may be important to your neuralgic problem; please describe below any problems you may have with the following):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> general well-being     | <input type="checkbox"/> ulcers                 | <input type="checkbox"/> chest pain             |
| <input type="checkbox"/> weight loss            | <input type="checkbox"/> indigestion            | <input type="checkbox"/> abnormal heart beat    |
| <input type="checkbox"/> memory                 | <input type="checkbox"/> diarrhea               | <input type="checkbox"/> heart palpitations     |
| <input type="checkbox"/> vision                 | <input type="checkbox"/> blood in stool         | <input type="checkbox"/> anxiety                |
| <input type="checkbox"/> hearing                | <input type="checkbox"/> bloating               | <input type="checkbox"/> nervousness            |
| <input type="checkbox"/> voice, speech          | <input type="checkbox"/> hernia                 | <input type="checkbox"/> arthritis              |
| <input type="checkbox"/> swallowing             | <input type="checkbox"/> joint pain or swelling | <input type="checkbox"/> sleep disturbance      |
| <input type="checkbox"/> abnormal neck swelling | <input type="checkbox"/> skin rashes            | <input type="checkbox"/> trouble with urination |
| <input type="checkbox"/> shortness of breath    | <input type="checkbox"/> sexual dysfunction     | <input type="checkbox"/> stroke                 |
| <input type="checkbox"/> constipation           | <input type="checkbox"/> seizures               | <input type="checkbox"/> infections             |
| <input type="checkbox"/> depression             | <input type="checkbox"/> loss of appetite       | <input type="checkbox"/> other _____            |

**PAST HISTORY:** (do you have or have you had any of the following and when?):

- |                             |                                     |
|-----------------------------|-------------------------------------|
| _____ High blood pressure   | _____ Tuberculosis                  |
| _____ Heart attack          | _____ Diabetes mellitus             |
| _____ Heart bypass surgery  | _____ Cancer                        |
| _____ Heart failure         | _____ Neurofibromatosis             |
| _____ Emphysema             | _____ Stroke                        |
| _____ Asthma                | _____ Aneurysm                      |
| _____ Blood vessel blockage | _____ Arthritis                     |
| _____ Seizures              | _____ Other _____                   |
| _____ Blood disorders       | _____ Bleeding / clotting disorders |
| _____ Brain hemorrhage      | _____ Brain Tumor                   |
| _____ Blood transfusion     |                                     |

List **SURGICAL PROCEDURES** you have had (include invasive procedures such as angioplasty, colon polyps, cystoscopy, etc.)

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Name: \_\_\_\_\_

List names and dosages of **MEDICATIONS** you take including non-prescription medicines:

Name	Strength	How Often

Are you **ALLERGIC** to any medications or drugs? No \_\_\_ Yes \_\_\_ (If yes list the drug name and type of reaction below):

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

**SOCIAL HISTORY:**

Occupation \_\_\_\_\_

Marital status \_\_\_\_\_

Tobacco use: yes \_\_\_ no \_\_\_ type \_\_\_\_\_ how long \_\_\_\_\_ how much per day \_\_\_\_\_

Alcohol use: yes \_\_\_ no \_\_\_ how much \_\_\_\_\_

Illicit drugs: \_\_\_\_\_

Have you traveled outside of the region, recently? Where \_\_\_\_\_ when \_\_\_\_\_

Highest level of education completed \_\_\_\_\_

**FAMILY HISTORY:** (do any of your blood kin relatives have a history of the following conditions and if so who?):

- |                             |                                     |
|-----------------------------|-------------------------------------|
| _____ High blood pressure   | _____ Tuberculosis                  |
| _____ Heart attack          | _____ Diabetes mellitus             |
| _____ Heart bypass surgery  | _____ Cancer                        |
| _____ Heart failure         | _____ Neurofibromatosis             |
| _____ Emphysema             | _____ Stroke                        |
| _____ Asthma                | _____ Aneurysm                      |
| _____ Blood vessel blockage | _____ Arthritis                     |
| _____ Seizures              | _____ Other                         |
| _____ Blood disorders       | _____ Bleeding / clotting disorders |
| _____ Brain hemorrhage      | _____ Brain Tumor                   |

Is there anything else about you that might affect your health or your response to medical treatment?

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

What doctors have you seen for this problem?

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

What tests have you had for this problem?

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

Patient signature \_\_\_\_\_

Physician signature \_\_\_\_\_