

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 | (G) Dust Cephalosporins |
| (8) Penicillin | (H) Codeine |
| (C) Tetracycline | (I) Iodine/8etadine |
| (O) Sulfa | (J) Radiographic Dyes |
| (E) Morphine | (K) Adhesive Tape |
| (F) Morphine | (L) Paint |
| (F) Erythromycin | (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 | (Q) COPD/Lung Problem |
| (8) Hypertension | (R) Immune disorder |
| (C) Coronary artery disease | (S) Overweight |
| (D) Peripheral vascular disease | (T) Osteomyelitis |
| (E) Adult onset diabetes | (U) Blood Clot (DVT) |
| (F) Childhood onset <i>diabetes</i> | (V) High Cholesterol |
| (G) Past heart attack | (W) Depression |
| (H) Asthma | (X) Anxiety |
| (I) Cancer | (Y) Headaches |
| (J) Ulcers | (Z) Kidney disease |
| (K) Hepatitis (A / 8 / C) | (AA) Rheumatoid Arthritis |
| (L) Tuberculosis | (CC) Osteoarthritis |
| (N) Liver disease | (DD) Circulation problems |
| (O) Seizure disorder | (EE) Eye Problems |
| (P) Thyroid disease | (FF) Ear Problems |
| Emphysema | 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

<u>Name</u>	<u>Dose</u> <u>(How many times a day)</u>	<u>For what problem?</u>
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Circle any surgeries listed below you may have had. Indicate the year of the surgery:

- | | |
|---------------------------|------------------------------|
| (A) No previous surgeries | (G) Hysterectomy _____ |
| (B) Appendectomy | (H) Lumber laminectomy _____ |
| (C) Cataract extraction | (I) Mastetomy _____ |
| (D) By-pass / open heart | (J) Tonsillectomy _____ |
| (E) Gall bladder | (K) Prostate surgery _____ |
| (F) Hernia repair | (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	Barbiturates _____	Cocaine _____
Heroin	Amphetamines _____	Marijuana _____
Other _____	Other _____	Other _____
(specify)	(specify)	(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	Barbiturates _____	Cocaine _____
Heroin	Amphetamines _____	Marijuana _____
Other _____	Other _____	Other _____
(specify)	(specify)	(specify)

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

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

Have you ever had a blood clot? Yes No

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

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

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

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

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. Unemployed
- 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 __