History Form

Name_____ Date_____

Main Problem

What pain causes you to come to the office? _____

What caused this pain? _____

When did this pain start? _____ How long does this pain last? _____

How bad is this pain? (Circle the one that applies) Mild, Moderate, Severe, Intolerable

Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lighteninglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike

How often does the pain occur? (Circle the one that applies) Occasional, Frequent, Constant

Does this pain travel to any other area? _____

What makes this pain better? _____

What makes this pain worse? _____

What else have you done to treat this pain? _____

Other Problem

What other pain do you have? _____

What caused this pain? _____

When did this pain start? _____ How long does this pain last? _____

How bad is this pain? (Circle the one that applies) Mild, Moderate, Severe, Intolerable

Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lighteninglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike

How often does the pain occur? (Circle the one that applies) Occasional, Frequent, Constant

Does this pain travel to any other area? _____

What makes this pain better? _____

What makes this pain worse? _____

What else have you done to treat this pain? _____

Allergies

Please list any allergies below including allergies to medication.

_____

_____

_____

Medications

Please list your current medications.

_____

_____

_____

History Form

Name_____ Date_____

Family History

Please tell us about the health of you grandparents, parents, siblings, and children. Circle or check everything that applies. If someone is deceased, please check or write in the cause.

	Living Deceased	Heart disease	Stroke	Cancer	Diabetes	Rheumatoid Arthritis	Kidney Disease	Lung Disease	Genetic Condition	Mental Condition
Paternal Grandfather	L D Cause									
Paternal Grandmother	L D Cause									
Maternal Grandfather	L D Cause									
Maternal Grandmother	L D Cause									
Father	L D Cause									
Mother	L D Cause									
Sibling M F	L D Cause									
Sibling M F	L D Cause									
Child M F	L D Cause									
Child M F	L D Cause									

Past History

Are you currently under treatment for any conditions _____

_____

Have you had any illnesses in the past _____

_____

Have you had any injuries _____

_____

Have you been hospitalized _____

Have you had any surgeries _____

List any medications that you are taking _____

_____

I certify that the information that I have given here is true and accurate to the best of my knowledge.

Signed_____ Date_____

History Form Part 2

Name_____ Date_____

Review of Systems

Check those conditions that you currently have or have had in the past. If you have none of the conditions listed in a section then check "All Negative".

Constitutional (General) ☐All Negative
☐Weight change ☐Fatigue ☐Fever or chills ☐Trouble sleeping
☐Weakness ☐Loss of appetite

Eyes ☐All Negative
☐ Eyesight problems ☐ Eye Pain ☐Eye discomfort ☐ Flashes
☐ Specks ☐ Redness Date of Last Eye Exam_____

Ears, Nose, Mouth, and Throat ☐All Negative
☐Difficulty hearing ☐ Ringing in ears ☐Ear pain ☐Vertigo
☐Nosebleeds ☐ Loss of smell ☐Sinus problems ☐ Itching
☐Sore throat ☐ Difficulty swallowing Date of Last Dental Exam_____

Cardiovascular (Heart) ☐All Negative
☐Chest pain or discomfort ☐ Fluttering in the chest ☐Leg swelling ☐Fainting
☐Tightness in chest ☐ Abnormal blood pressure ☐Shortness of breath with activity

Respiratory (Lungs) ☐All Negative
☐Cough ☐ Shortness of breath ☐Wheezing ☐Snoring
☐Painful breathing ☐ Difficult breathing w/exercise

Gastrointestinal (Stomach) ☐All Negative
☐Heartburn ☐Difficulty swallowing ☐Constipation ☐Diarrhea
☐Abdominal pain ☐Black or bloody stool ☐Yellow eyes or skin ☐Nausea

Genitourinary ☐All Negative
☐Painful urination ☐Increased frequency ☐Blood in urine ☐Incontinence
☐Urgency ☐Painful sex ☐Loss of libido ☐Impotence
Date of Last Menstrual Period_____

Musculoskeletal ☐ All Negative
☐ Neck pain ☐Low Back Pain ☐ Mid back pain ☐ Joint pain
☐ Pain radiating to arms R L ☐Pain radiating to legs R L ☐ Muscle pain ☐ Stiffness

Integumentary (Skin and/or Breast) ☐All Negative
☐Rash ☐Changes in a mole ☐ Sores ☐Itching
☐Dry skin ☐Unusual growth ☐Breast lump ☐Breast pain

Neurological (Brain and Nerves) ☐All Negative
☐Headaches ☐Seizures ☐Dizziness ☐ Fainting
☐Numbness ☐Tingling ☐Tremors ☐Paralysis
☐Lack of coordination ☐Memory loss ☐Loss of strength ☐Confusion

History Form Part 2

Name_____ Date_____

Psychiatric ☐All Negative

☐Anxiety	☐Depression	☐Mood swings	☐Suicidal
☐Loss of interest	☐Phobias	☐Hallucinations	☐Insomnia

Endocrine ☐All Negative

☐Heat intolerant	☐Cold intolerant	☐Hair changes	☐Sweating
☐Change in appetite	☐Frequent urination	☐Thirst	☐Hot flashes

Hematologic/Lymphatic (Blood) ☐ All Negative

☐Bleeding problems	☐Bruises easily	☐Enlarged glands	☐Anemia
☐Bleeding gums	☐Unexplained swelling		

Allergic/Immunologic ☐All Negative

☐Food allergies	☐Medication allergies	☐Seasonal allergies	☐Hives/Eczema
☐Frequent infections			

Any other problems _____

Social History

Do you currently use tobacco? Y N What type_____ How frequently_____

When did you start_____ Has your usage increased or decreased recently Y N

Did you use tobacco in the past? Y N When did you quit_____ How long did you use it_____

Do you currently use alcohol? Y N What type_____ How frequently_____

When did you start_____ Has your usage increased or decreased recently Y N

Do you currently use recreational drugs? Y N What type_____ How frequently_____
When did you start_____ Has your usage increased or decreased recently Y N

Are you currently employed? Y N What type of work do or did you do_____

Have you had any STDs? Y N Have you been in prison? Y N

Have you traveled within the country recently? Y N Have you traveled out of the country recently? Y N

Do you exercise regularly? Y N What type_____ How frequently _____

Describe your diet_____

_____

I certify that the information that I have given here is true and accurate to the best of my knowledge.

Signed_____ Date_____

History Update

Name_____ Date_____

Main Problem Is the pain that caused you to come to this office better or worse? Better Worse

How bad is this pain now? (Circle the one that applies) Mild, Moderate, Severe, Intolerable

Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lighteninglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike

How often does the pain occur now? (Circle the one that applies) Occasional, Frequent, Constant

Does this pain travel to any other area? _____

Other Problem Is the secondary pain better or worse? Better Worse

How bad is this pain now? (Circle the one that applies) Mild, Moderate, Severe, Intolerable

Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lighteninglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike

How often does the pain occur now? (Circle the one that applies) Occasional, Frequent, Constant

Does this pain travel to any other area? _____

New Problem Do you have any new pain(s) that you did not have when you started care? Yes No

Describe the pain(s) _____

_____

What caused this pain? _____

When did this pain start? _____ How long does this pain last? _____

How bad is this pain? (Circle the one that applies) Mild, Moderate, Severe, Intolerable

Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lighteninglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike

How often does the pain occur? (Circle the one that applies) Occasional, Frequent, Constant

Does this pain travel to any other area? _____

What makes this pain better? _____

What makes this pain worse? _____

I certify that the information that I have given here is true and accurate to the best of my knowledge.

Signed_____ Date_____