CONFIDENTIAL PATIENT CASE HISTORY

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

Name _____ Birthday _____

Anatomy at Birth ❑ M ❑ F Chosen Gender: ❑ M ❑ F ❑Other _____

Address _____City _____Zip _____

Last 4 Soc.Sec. # _____ Home Phone _____ Work _____

Cell _____ E-Mail _____

Marital Status: ❑ M ❑ S ❑ D ❑ W Children, Ages _____ Spouse's Name _____

Race: ❑Asian ❑Black or African Amer ❑White ❑Native Amer ❑Pacific Island ❑Other_____

Ethnicity: ❑Caucasian ❑Black or African Amer ❑Hispanic/Latino ❑Other_____

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? _____ This or similar conditions occurred in the past? ❑Y ❑N

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 _____

When was the last time you saw that doctor for the 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 _____

_____ _

Patient Name_____

Parent/Guardian *(If Applicable)*_____

Signature_____ Date_____

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

GENERAL			THROAT			GASTROINTESTINAL		
Weakens	□ Now	□ Past	Soreness	□ Now	□ Past	Abdominal pain	□ Now	□ Past
Fatigue	□ Now	□ Past	Bad Tonsils	□ Now	□ Past	Nausea	□ Now	□ Past
Fever	□ Now	□ Past	Hoarseness	□ Now	□ Past	Bloated	□ Now	□ Past
Chills	□ Now	□ Past	Pain	□ Now	□ Past	Belching	□ Now	□ Past
Night Sweats	□ Now	□ Past	Trouble Swallowing	□ Now	□ Past	Heartburn	□ Now	□ Past
Fainting	□ Now	□ Past	Recurrent Infections	□ Now	□ Past	Indigestion	□ Now	□ Past
SKIN			**NECK**			Irregular Bowel Habits	□ Now	□ Past
Color Changes	□ Now	□ Past	Neck Enlargement	□ Now	□ Past	Constipation	□ Now	□ Past
Nail Changes	□ Now	□ Past	Stiff Neck	□ Now	□ Past	Diarrhea	□ Now	□ Past
Hair Changes	□ Now	□ Past	Soreness	□ Now	□ Past	Gas	□ Now	□ Past
Moles	□ Now	□ Past	Lumps	□ Now	□ Past	Hemorrhoids	□ Now	□ Past
Rashes	□ Now	□ Past	Masses	□ Now	□ Past	Poor appetite	□ Now	□ Past
Sores	□ Now	□ Past	**BREASTS**			Food Intolerance	□ Now	□ Past
Weakness	□ Now	□ Past	Discharge	□ Now	□ Past	Bloody Stools	□ Now	□ Past
HEAD	□ Now	□ Past	Lumps	□ Now	□ Past	Black Stools	□ Now	□ Past
Headaches	□ Now	□ Past	Pain	□ Now	□ Past	**GENITOURINARY**		
Injuries	□ Now	□ Past	Bleeding	□ Now	□ Past	Urgency	□ Now	□ Past
Bumps	□ Now	□ Past	Nipple Changes	□ Now	□ Past	Incontinence	□ Now	□ Past
Glasses/ Contacts	□ Now	□ Past	Skin Changes	□ Now	□ Past	Straining	□ Now	□ Past
Cataracts	□ Now	□ Past	Bloated	□ Now	□ Past	Back Pain	□ Now	□ Past
EARS			**LUNGS**			Frequent Voiding	□ Now	□ Past
Hard of Hearing	□ Now	□ Past	Coughs	□ Now	□ Past	Stones	□ Now	□ Past
Deafness	□ Now	□ Past	Phlegm	□ Now	□ Past	Burning	□ Now	□ Past
Ringing	□ Now	□ Past	Blood	□ Now	□ Past	Bed Wetting	□ Now	□ Past
Discharge	□ Now	□ Past	Short of Breath	□ Now	□ Past	Small Stream	□ Now	□ Past
Earache	□ Now	□ Past	Wheezing	□ Now	□ Past	Discharge	□ Now	□ Past
Itching	□ Now	□ Past	Pain	□ Now	□ Past	Impotence	□ Now	□ Past
Dizziness	□ Now	□ Past	Congestion	□ Now	□ Past	Dribbling	□ Now	□ Past
Room Spins	□ Now	□ Past	Inhalant Exposure	□ Now	□ Past	Cloudy Urine	□ Now	□ Past
NOSE			**HEART**			Urine Color	_____	
Decreased Smell	□ Now	□ Past	Murmur	□ Now	□ Past	Spotting Between		
Bleeding	□ Now	□ Past	Palpitations	□ Now	□ Past	Periods	□ Now	□ Past
Pain	□ Now	□ Past	Rapid Heartbeat	□ Now	□ Past	Menstrual Cramps	□ Now	□ Past
Discharge	□ Now	□ Past	Swollen Extremities	□ Now	□ Past	Discharge	□ Now	□ Past
Obstruction	□ Now	□ Past	Cold Extremities	□ Now	□ Past	Itching	□ Now	□ Past
Post Nasal Drip	□ Now	□ Past	Chest Pain/Pressure	□ Now	□ Past	Painful Intercourse	□ Now	□ Past
Deviated Septum	□ Now	□ Past	Varicose Veins	□ Now	□ Past	Irregular Periods	□ Now	□ Past
Runny Nose	□ Now	□ Past	Blood Clots	□ Now	□ Past	Hot Flashes	□ Now	□ Past
Sinus Congestion	□ Now	□ Past	Blue Extremities	□ Now	□ Past	Contraception Type	_____	
MOUTH			**BLOOD**	□ Now	□ Past	Age at First Period	_____	
Bleeding Gums	□ Now	□ Past	Anemia	□ Now	□ Past	Duration of Cycle_____	Duration of Flow _____	
Sores	□ Now	□ Past	Low Blood Iron	□ Now	□ Past	# of Pregnancies _____ # Births _____		
Dental Problems	□ Now	□ Past	Easy Bruising	□ Now	□ Past	# Miscarriages _____ # Abortions _____		
Bad Breath	□ Now	□ Past	Easy Bleeding	□ Now	□ Past	Menstrual Flow □Heavy □Mod □Light		
Loss of Taste	□ Now	□ Past	Swollen Nodes	□ Now	□ Past	Last Period	_____	
Dry Mouth	□ Now	□ Past	Painful Nodes	□ Now	□ Past	Last Pap Smear	_____	
Ulcers	□ Now	□ Past	Sugar in Blood	□ Now	□ Past	Last Vaginal Exam	_____	
Blisters	□ Now	□ Past	Red spots	□ Now	□ Past	Last Mammogram	_____	

Patient Name_____ Date _____

NEUROLOGIC		
Seizures	Now	Past
Vertigo	Now	Past
Dizziness	Now	Past
Hand Trembling	Now	Past
Loss of Sensation	Now	Past
In coordination	Now	Past
Loss of Facial	Now	Past
Weak Grip	Now	Past
Paralysis	Now	Past
Difficulty Speech	Now	Past
Tingling	Now	Past
Loss of Memory	Now	Past
Numbness	Now	Past

PSYCHIATRIC		
Hyperventilation	Now	Past
Insecurity	Now	Past
Depression	Now	Past
Troubled Sleep	Now	Past
Irritable	Now	Past
Undecidedness	Now	Past
Timid	Now	Past
Hallucinations	Now	Past
Loss of Memory	Now	Past
Drug addiction	Now	Past
Drug Dependent	Now	Past
Suicidal Thoughts	Now	Past
Extreme Worry	Now	Past
Sexual Problems	Now	Past

MUSCULOSKELETAL		
Muscle Pain	Now	Past
Muscle Weakness	Now	Past
Muscle cramps	Now	Past
Muscle Twitching	Now	Past
Joint Stiffness	Now	Past
Joint Pain	Now	Past
ENDOCRINE	Now	Past
Weight Loss	Now	Past
Weight Gain	Now	Past
Extremely Thin	Now	Past
Heat Intolerance	Now	Past
Cold Intolerance	Now	Past
Hair changes	Now	Past
Breast Changes	Now	Past

IMMUNUZATIONS	
DPT	Current
Mumps	Current
Smallpox	Current
Typhoid	Current
Tetanus	Current
Measles	Current
Pneumococcal	Current
Influenza	Current
Polio	Current
MMR	Current
COVID 19	Current

BLOOD TYPE

A+ □ A □-

B+ □ B □-

AB+ □ AB □-

O+ □ O □-

Other _____

BLOOD TRANSFUSION

Date _____

Date _____

Date _____

PAST MEDICAL HISTORY

Check only the ones that you have had in the past

COVID 19	Yes	Parasites	Yes
Hay Fever	Yes	Epilepsy	Yes
Mumps	Yes	Paralysis	Yes
Rheumatic fever	Yes	Polio	Yes
Allergies	Yes	Mental Illness	Yes
Angina	Yes	Alcoholism	Yes
Cancer	Yes	Depression	Yes
Tumor	Yes	Nervous Breakdown	Yes
Blood Disease	Yes	Migraine	Yes
Leukemia	Yes	Gout	Yes
Heart Trouble	Yes	Hemorrhoids	Yes
Varicose Veins	Yes	Prostrate problems	Yes
Phlebitis	Yes	Sexual Problems	Yes
Hypertension	Yes	Gonorrhea	Yes
Stroke	Yes	Syphilis	Yes
Ulcers	Yes	Diabetes	Yes
Jaundice	Yes	Bladder Trouble	Yes
Skin Trouble	Yes	Kidney Stones	Yes
Gallstones	Yes	Kidney Infections	Yes
Liver trouble	Yes	Dysentery	Yes
Hepatitis	Yes		

Date of Last Chest X -Ray _____ □Normal Abnormal

Lat TB Skin Test _____ □Normal Abnormal

Allergies

Other:

Patient Name_____ Date _____

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	Illness
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal					
Grandfather					
Maternal					
Grandmother					
Paternal					
Grandfather					
Paternal					

SOCIAL HISTORY

Check the boxes and fill in

Current weight _____ Have you recently lost of gained weight? _____

Mental Work □ Heavy □Mod □Light Hours per day _____
Physical Work □ Heavy □Mod □Light Hours per day _____
Exercise □ Heavy □Mod □Light Hours per day _____
Smoking □ Heavy □Mod □Light Hours per day _____

Alcohol: amount per week
Beer _____ Liquor _____ Wine _____ # of years _____

Caffeine: (Coffee, tea, Cola)
Cups per day _____ # of years _____

Aspirin
per day _____ # of years _____

MARK THE AREAS OF YOUR SYMTOMS ON THE FIGURE

Use the following symbols:

Aches ʌʌʌʌ Numbness **OOOO** Pins/needles ●●●● Stabbing**///**

Mark a "X"on the lines below

How bad were your symptoms last week?

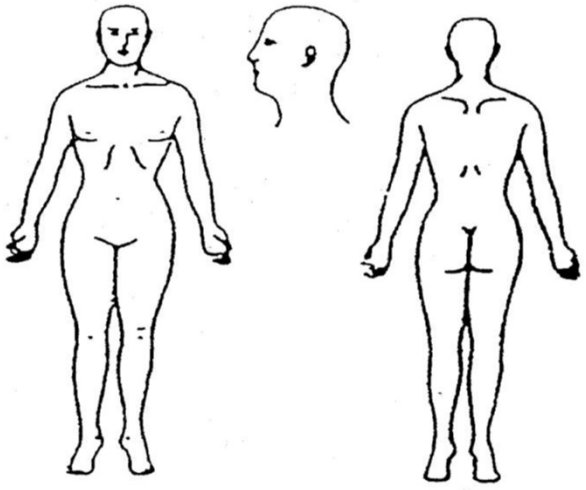
_____

None Most Severe

How bad are your symptoms now?

_____

None Most Severe



Patient Name_____..Date _____