CONFIDENTIAL PATIENT CASE HISTORY

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

Today's Date / / Signature of Patient _____

Signature of Parent/Guardian _____

Patient Title: (check one) ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Miss ◯ Dr. ◯ Prof. ◯ Rev.

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Mobile Phone _____

Home Email _____ Work Email _____

Which email address would you like us to use to communicate with you? (Check one)

◯ Home ❑ Work

Contact Method (Check one)

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / Age _____ Gender (Check one) ◯ Male ◯ Female ◯ Unspecified

Marital Status (Check one) ◯ Single ◯ Married ◯ Other SSN _____

Employment Status (Check one)

◯ Employed ◯ FT Student ◯ PT Student ◯ Other ◯ Retired ◯ Self Employed

Race (Check one)

◯ White ◯ Black/African American ◯ Hispanic ◯ American Indian/Alaskan Native
◯ Asian ◯ Asian Indian ◯ Chinese ◯ Filipino
◯ Japanese ◯ Korean ◯ Vietnamese ◯ Native Hawaiian or other Pacific Island
◯ Samoan ◯ Guamanian or Chamorro ◯ Other_____ ◯ I choose not to specify

Multi-Racial (Check one) ◯ Yes ◯ No ◯ Unknown

Ethnicity (Check one) ◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ I choose not to specify

Preferred Language (Check one)

◯ English ◯ Spanish ◯ American Sign Language ◯ Chinese ◯ French ◯ German
◯ Tagalog ◯ Vietnamese ◯ Italian ◯ Korean ◯ Russian ◯ Polish
◯ Arabic ◯ Portuguese ◯ Japanese ◯ French Creole ◯ Greek ◯ Hindi
◯ Persian ◯ Urdu ◯ Gujarati ◯ Armenian ◯ I choose not to specify

Verification Question (Choose only one question by checking the question, then give the answer to that question)

◯ What is the name of your favorite pet? ◯ In what city were you born? ◯ What high school did you attend?
◯ What is your favorite movie? ◯ What is your mother's maiden name? ◯ On what street did you grow up?
◯ What was the make of your first car? ◯ When is your anniversary? ◯ What is your favorite color?

Verification Answer to the Chosen question: _____

Do you currently smoke tobacco of any kind? ◯ Yes ◯ Former smoker ◯ Never been a smoker

If yes, how often do you smoke: ◯ Current every day smoker ◯ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

No interest Very Interested

Current medications, including dosage if known.
If there are no current medications, check here: ☐

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

List any known allergies you have had to any medications.
If no allergies are known, check here: ☐

1) _____ 3) _____

2) _____ 4) _____

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 therapists who have treated THIS ____ condition _____

_____

_____

What do you think caused this condition? _____

List surgical operations and years: _____

_____

_____

Do you have a family physician? Name : _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ◯ Yes ◯ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ◯ Yes ◯ No If yes, what kind? ◯ Type I ◯ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ◯ Yes ◯ No ◯ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back_____ spine in the past 28 days? ◯ Yes ◯ No

To be performed by clinic staff:

Height: _____inches Weight: _____ pounds BP: _____ / _____

REVIEW OF SYSTEMS Check only the ones you now have____ or have had__ in the past.

GENERAL	NOW	PAST
Weakness	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Fainting	☐	☐
SKIN		
Color Changes	☐	☐
Nail Changes	☐	☐
Hair Changes	☐	☐
Moles	☐	☐
Rashes	☐	☐
Sores	☐	☐
Weakness	☐	☐
HEAD		
Headaches	☐	☐
Injuries	☐	☐
Bumps	☐	☐
Last Eye Exam	_____	
Glasses	☐	☐
Contacts	☐	☐
Cataracts	☐	☐
EARS		
Hard of Hearing	☐	☐
Deafness	☐	☐
Ringing	☐	☐
Discharge	☐	☐
Earache	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Room Spins	☐	☐
NOSE		
Decreased Smell	☐	☐
Bleeding	☐	☐
Pain	☐	☐
Discharge	☐	☐
Obstruction	☐	☐
Post Nasal Drip	☐	☐
Deviated Septum	☐	☐
Runny Nose	☐	☐
Sinus Congestion	☐	☐
MOUTH		
Bleeding Gums	☐	☐
Sores	☐	☐
Dental Problems	☐	☐
Bad Breath	☐	☐
Loss of Taste	☐	☐
Dry Mouth	☐	☐
Ulcers	☐	☐
Blisters	☐	☐

THROAT	NOW	PAST
Soreness	☐	☐
Bad Tonsils	☐	☐
Hoarseness	☐	☐
Pain	☐	☐
Trouble Swallowing	☐	☐
Recurrent Infections	☐	☐
NECK		
Neck Enlargement	☐	☐
Stiff Neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐
BREASTS		
Discharge	☐	☐
Lumps	☐	☐
Pain	☐	☐
Bleeding	☐	☐
Nipple Changes	☐	☐
Skin Changes	☐	☐
Bloated	☐	☐
LUNGS		
Cough	☐	☐
Phlegm	☐	☐
Blood	☐	☐
Short of Breath	☐	☐
Wheezing	☐	☐
Pain	☐	☐
Congestion	☐	☐
Inhalant Exposure	☐	☐
HEART		
Murmur	☐	☐
Palpitations	☐	☐
Rapid Heartbeat	☐	☐
Swollen Extremities	☐	☐
Cold Extremities	☐	☐
Chest Pain/Pressure	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Blue Extremities	☐	☐
BLOOD		
Anemia	☐	☐
Low Blood Iron	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Swollen Nodes	☐	☐
Painful Nodes	☐	☐
Sugar in Blood	☐	☐
Red Spots	☐	☐

GASTROINTESTINAL	NOW	PAST
Abdominal Pain	☐	☐
Nausea	☐	☐
Bloated	☐	☐
Belching	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Irregular Bowel Habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Hemorrhoids	☐	☐
Poor Appetite	☐	☐
Food Intolerance	☐	☐
Bloody Stools	☐	☐
Black Stools	☐	☐
GENITOURINARY		
Urgency	☐	☐
Incontinence	☐	☐
Straining	☐	☐
Back Pain	☐	☐
Frequent Voiding	☐	☐
Stones	☐	☐
Burning	☐	☐
Bed Wetting	☐	☐
Small Stream	☐	☐
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Cloudy Urine	☐	☐
Urine Color	_____	
Spotting Between Periods	☐	☐
Menstrual Cramps	☐	☐
Discharge	☐	☐
Itching	☐	☐
Painful Intercourse	☐	☐
Irregular Periods	☐	☐
Hot Flashes	☐	☐

Contraception Type _____
Age at First Period _____
Duration of Cycle _____
Duration of Flow _____
No. of Pregnancies _____
No. of Births _____
No. of Miscarriages _____
No. of Abortions _____
Menstrual Flow ☐Heavy ☐Mod ☐Light
Last Period _____
Last Pap Smear _____
Last Vaginal Exam _____
Last Mammogram _____
Last Prostate Exam _____

Patient Name_____ Number _____ Date _____

 FORM 101

NEUROLOGIC	NOW	PAST
Seizures	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Hand Trembling	☐	☐
Loss of Sensation	☐	☐
Incoordination	☐	☐
Loss of Facial	☐	☐
Weak Grip	☐	☐
Paralysis	☐	☐
Difficulty Speech	☐	☐
Tingling	☐	☐
Loss of Memory	☐	☐
Numbness	☐	☐

ENDOCRINE		
Weight Loss	☐	☐
Weight Gain	☐	☐
Extremely Thin	☐	☐
Heat Intolerance	☐	☐
Cold Intolerance	☐	☐
Hair Changes	☐	☐
Breast Changes	☐	☐

IMMUNIZATION/VACCINATION	
DPT	☐
Mumps	☐
Smallpox	☐
Typhoid	☐
Tetanus	☐
Measles	☐
Pneumococcal	☐
Influenza	☐
Polio	☐
MMR	☐

BLOOD TYPE			
A +	☐	A -	☐
B +	☐	B -	☐
AB +	☐	AB -	☐
O +	☐	O -	☐

Other _____

BLOOD TRANSFUSIONS

Date_____

Date_____

Date_____

Date_____

PSYCHIATRIC	NOW	PAST
Hyperventilation	☐	☐
Insecurity	☐	☐
Depression	☐	☐
Troubled Sleep	☐	☐
Irritable	☐	☐
Undecidedness	☐	☐
Timid	☐	☐
Hallucinations	☐	☐
Loss of Memory	☐	☐
Alcoholism	☐	☐
Drug Addiction	☐	☐
Drug Dependent	☐	☐
Suicidal Thoughts	☐	☐
Extreme Worry	☐	☐
Sexual Problems	☐	☐

MUSCULOSKELETAL	NOW	PAST
Muscle Pain	☐	☐
Muscle Weakness	☐	☐
Muscle Cramps	☐	☐
Muscle Twitching	☐	☐
Joint Stiffness	☐	☐
Joint Pain	☐	☐

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

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

Date of Last Chest X-Ray _____ ◯Normal ◯Abnormal

Last TB Skin Test _____ ◯Normal ◯Abnormal

Allergies: _____

_____

_____

_____

_____

Patient Name_____ Number _____ Date _____

 FORM 101

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? _____

Mental Work ○Heavy ○Moderate ○Light Hours per day _____

Physical Work ○Heavy ○Moderate ○Light Hours per day _____

Exercise ○Heavy ○Moderate ○Light Hours per week _____ Type _____

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

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

Aspirin No./Day _____ No. of Years _____ Others _____

SYMPTOMS 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 following two lines:

How bad are your symptoms now?

_____
None Most Severe

How bad have they been in the past?

_____
None Most Severe