Name and Account #: **DOB:**

10. Have you had any: Xrays, MRI's, CAT Scans, NCV, EMG's, Ultrasounds, or any other diagnostic test?

When: _____ Test: _____ Body Area: _____ Where: _____
When: _____ Test: _____ Body Area: _____ Where: _____

11. Previous treatments, medications, or surgery for <u>THIS</u> complaint: _____

12. <u>Past Health History</u>

- ☐ Recent Fever
- ☐ Diabetes
- ☐ Headaches
- ☐ High Blood Pressure
- ☐ Stroke (date) _____
- ☐ Corticosteriod Use (prednisone, cortisone)
- ☐ Dizziness/Fainting/Balance
- ☐ Lymes Disease
- ☐ Cancer/Tumor (explain) _____
- ☐ Eye/Visual Disturbances
- ☐ Arthritis
- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Urinary Problems
- ☐ Epilepsy/Seizures
- ☐ Currently Pregnant, # weeks _____
- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Marked Morning Pain/Stiffness
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Osteoporosis
- ☐ Autoimmune Disease

- ☐ Surgeries _____
- ☐ Problems with the following (circle) Skin, Breast, Hearing, Stomach, Intestinal, Kidney, Psychological (explain) _____
- ☐ Allergies _____
- ☐ Other Health Problems (explain) _____

13. <u>PLEASE LIST ALL</u> Medications you are presently or have recently taken and <u>REASON:</u>

MEDICATION _____ REASON _____
MEDICATION _____ REASON _____
MEDICATION _____ REASON _____

***IF MORE ROOM IS NEEDED, PLEASE ASK FOR AN ADDITIONAL SHEET**

14. <u>Females Only</u>

A. # of Pregnancies _ # of Births _____ Complications: _____

B. What was the start date of your **<u>last menstrual period</u>**? _____ *(In case X-rays or other tests are ordered)

C. Are you presently taking or using any **<u>Birth Control Medication or Devices</u>**? YES NO Type: _____

D. Have you had a **<u>Mammogram</u>**? YES NO Date: _____ Results: Positive / Negative

16. <u>Family Health History</u>

☐**Cancer** ☐**Heart Problems/Stroke** ☐**Diabetes** ☐**Rheumatoid Arthritis** ☐**High Blood Pressure**

A. Cause of parent(s) or sibling(s) death(s)/ Age at death? _____

17. <u>Social and Occupational History:</u>

A. Level of Education: ☐Grade School ☐High School ☐Some College ☐College Graduate ☐Post Graduate

B. Job Description: _____ Work Schedule: # of Hours/ week _____

C. Recreational activities: _____

D. Lifestyle (hobbies, level of weekly exercise, diets): _____

E. Do you currently smoke or have smoked in the past? YES NO Are you still smoking? YES NO
# of Packs per day: _____ # of Years Used: _____

F. Do you currently or have you previously used any **<u>Illegal drugs</u>** or over utilized any **<u>Prescription Medications</u>**? YES NO
Are you still using the drug(s)? YES NO **TYPE/AMOUNT:** _____

(Patient/Guardian) Signature: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____