NAME: DATE: / /

HISTORY OF ILLNESS / INJURY /PAIN

LOCATION

Chief complaint and its location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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TIMING & DURATION How often do you experience this pain? \_\_\_\_ Constant \_\_\_\_ Frequently \_\_\_\_ Intermittent \_\_\_\_ Occasional

What caused the onset?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Date of onset? / / (Please list your most recent incident (minor or major) that prompted this visit.)

SEVERITY

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate

6 = Moderate to Severe 7 = Mildly Severe 8 = Severe, Limits Most Activity 9 = Very Severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

 \_\_\_\_ 0 \_\_\_\_ 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

What is the least intense the symptom has been on a scale of 0 to 10?

 \_\_\_\_ 0 \_\_\_\_ 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

What is the most intense the symptom has been on a scale of 0 to 10?

 \_\_\_\_ 0 \_\_\_\_ 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply => \_\_\_\_Inflexibility \_\_\_Stiffness \_\_\_\_Spasms \_\_\_\_Cramps

If this pain radiates or travels, please identify where to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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QUALITY

How would you best describe the sensation of the pain/symptom:

\_\_\_\_ Sharp \_\_\_\_ Stabbing \_\_\_\_ Aching \_\_\_\_ Pins & Needles \_\_\_\_ Pounding \_\_\_\_ Shooting

\_\_\_\_ Burning \_\_\_\_ Dull \_\_\_\_ Tingling/Numb \_\_\_\_Throbbing \_\_\_\_ Crawling \_\_\_\_ Stinging

MODIFYING FACTORS

What aggravates the pain/symptom?

\_\_\_\_ Sneezing \_\_\_\_ Lifting \_\_\_\_ Exercising \_\_\_\_ Looking up/down \_\_\_\_ Walking

\_\_\_\_ Coughing \_\_\_\_ Sitting \_\_\_\_ Stooping \_\_\_\_ Looking side/side \_\_\_\_ Standing

\_\_\_\_ Stress \_\_\_\_ Driving \_\_\_\_ Getting out of bed \_\_\_\_ Pushing \_\_\_\_ Pulling

\_\_\_\_ Repetitive movement \_\_\_\_ Carrying \_\_\_\_ Straining at BM \_\_\_\_ Climbing Stairs \_\_\_\_ Getting in/out of car

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What relieves this pain/symptom?

 \_\_\_\_ Resting \_\_\_\_ Sleeping \_\_\_\_ Lifting \_\_\_\_ Exercising \_\_\_\_ Looking up/down

 \_\_\_\_ Shower \_\_\_\_ Advil \_\_\_\_ Stooping \_\_\_\_ Looking side/side \_\_\_\_ Mineral Ice

 \_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Over the past weeks/months this complaint is: \_\_\_\_ Improving \_\_\_\_ Getting worse \_\_\_\_ About the same

Have you seen anyone for this condition? \_\_\_\_ YES \_\_\_\_ NO WHOM? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: DATE: / /

SECONDARY COMPLAINT & LOCATION

Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sitting here today, right now, what is the intensity of the pain on a scale of 0 to 10?

 \_\_\_\_ 0 \_\_\_\_ 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

What is the least intense the symptom has been on a scale of 0 to 10?

 \_\_\_\_ 0 \_\_\_\_ 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

What is the most intense the symptom has been on a scale of 0 to 10?

 \_\_\_\_ 0 \_\_\_\_ 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply => \_\_\_\_Inflexibility \_\_\_Stiffness \_\_\_\_Spasms \_\_\_\_Cramps

If this pain radiates or travels, please identify where to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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QUALITY

How would you best describe the sensation of the pain/symptom:

\_\_\_\_ Sharp \_\_\_\_ Stabbing \_\_\_\_ Aching \_\_\_\_ Pins & Needles \_\_\_\_ Pounding \_\_\_\_ Shooting

\_\_\_\_ Burning \_\_\_\_ Dull \_\_\_\_ Tingling/Numb \_\_\_\_Throbbing \_\_\_\_ Crawling \_\_\_\_ Stinging

Over the past weeks/months this complaint is: \_\_\_\_ Improving \_\_\_\_ Getting worse \_\_\_\_ About the same

THIRD COMPLAINT & LOCATION

Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sitting here today, right now, what is the intensity of the pain on a scale of 0 to 10?

 \_\_\_\_ 0 \_\_\_\_ 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

What is the least intense the symptom has been on a scale of 0 to 10?

 \_\_\_\_ 0 \_\_\_\_ 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

What is the most intense the symptom has been on a scale of 0 to 10?

 \_\_\_\_ 0 \_\_\_\_ 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply => \_\_\_\_Inflexibility \_\_\_Stiffness \_\_\_\_Spasms \_\_\_\_Cramps

If this pain radiates or travels, please identify where to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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QUALITY

How would you best describe the sensation of the pain/symptom:

\_\_\_\_ Sharp \_\_\_\_ Stabbing \_\_\_\_ Aching \_\_\_\_ Pins & Needles \_\_\_\_ Pounding \_\_\_\_ Shooting

\_\_\_\_ Burning \_\_\_\_ Dull \_\_\_\_ Tingling/Numb \_\_\_\_Throbbing \_\_\_\_ Crawling \_\_\_\_ Stinging

Over the past weeks/months this complaint is: \_\_\_\_ Improving \_\_\_\_ Getting worse \_\_\_\_ About the same

KEY VALUE QUESTIONS

1. What is your pain keeping you from doing that is most important in your life?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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2. What do you enjoy doing most in your life?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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NOTES / COMMENTS:

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Doctor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: DATE: / /

**Please circle the condition that applies to you: P = Present N = Not Present PP = If it has ever been present in the past**

**P N PP** Fatigue **P N PP** Irritability **P N PP** Joint Stiffness **P N PP** Seizures

**P N PP** Fever **P N PP** Depression **P N PP** Spinal Curvature **P N PP** Dizziness

**P N PP** Chills **P N PP** Memory Loss **P N PP** Back Pain **P N PP** Tremors

**P N PP** Night Sweats **P N PP** Headache **P N PP** Hot Joints **P N PP** Loss of Sensation

**P N PP** Fainting **P N PP** Muscle Pain **P N PP** Joint Swelling **P N PP** Loss of Coordination

**P N PP** Nervousness **P N PP** Muscle Weakness **P N PP** Stiff Neck **P N PP** Paralysis

**P N PP** Concentration Loss **P N PP** Muscle Cramps **P N PP** Lumps / Masses **P N PP** Difficulty of Speech

**P = Present N = Not Present PP = If it has ever been present in the past. Do the same for your family**

**Family History Key: F = Father M = Mother B = Brother S = Sister GF = Grandfather GM = Grandmother**

 **Past Problem When and Explanation of Condition (use back if needed)**

**P N PP** Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ F M B S GF GM

**P N PP** Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ F M B S GF GM

**P N PP** Thyroid Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ F M B S GF GM

**P N PP** Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ F M B S GF GM

**P N PP** Heart Attack \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ F M B S GF GM

**P N PP** HIV \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ F M B S GF GM

**P N PP** Angina/Chest Pains \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ F M B S GF GM

**P N PP** Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ F M B S GF GM

**P N PP** Arthritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ F M B S GF GM

**P N PP** Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ F M B S GF GM

**List any allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Do you have a pacemaker? \_\_\_\_\_ YES \_\_\_\_\_NO Are you pregnant? \_\_\_\_\_ YES \_\_\_\_\_ NO**

 **Do you think you may be pregnant? \_\_\_\_\_ YES \_\_\_\_\_ NO**

FOR DOCTOR’S USE ONLY – PATIENT PLEASE PROCEED TO PAGE 4

**REVIEW OF SYSTEMS**

SYSTEM REVIEWED

Allergic / Immunologic Genitourinary Cardiovascular Hematological / Lymphatic

Constitutional Integumentary Ears / Nose / Mouth Musculoskeletal

Endocrine Neurological Eyes Psychiatric

Gastrointestinal Respiratory All other system reviews negative

Notes / Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Doctor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: DATE: / /

PLEASE LIST PAST SURGERIES:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YEAR \_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YEAR \_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YEAR \_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YEAR \_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YEAR \_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YEAR \_\_\_\_\_\_\_\_

List any other key slips, falls or accidents you’ve had from childhood to present: Date Have you even taken:

1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insulin YES NO YEAR \_\_\_\_\_\_\_\_\_\_

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cortisone YES NO YEAR \_\_\_\_\_\_\_\_\_\_

3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Thyroid Medicine YES NO YEAR \_\_\_\_\_\_\_\_\_\_

4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male/Female Hormones YES NO YEAR \_\_\_\_\_\_\_\_\_\_

5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood Pressure YES NO YEAR \_\_\_\_\_\_\_\_\_\_

 Tranquilizers/Sedatives YES NO YEAR \_\_\_\_\_\_\_\_\_\_

What medications are you currently taking? (Include Date) Birth Control YES NO YEAR \_\_\_\_\_\_\_\_\_\_

1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_6)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known allergies to medications:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Hospitalizations:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Single \_\_\_\_ Separated \_\_\_\_Widowed

Number of Children: \_\_\_\_ Children’s Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of Exercise: \_\_\_\_ Never \_\_\_\_ Rarely \_\_\_\_ Occasionally \_\_\_\_ Moderately \_\_\_\_ Regularly

Intensity of Exercise: \_\_\_\_ Low Level \_\_\_\_ Medium Level \_\_\_\_ High Level \_\_\_\_ Competition Level

Sufficient Rest: \_\_\_\_ Never \_\_\_\_ Rarely \_\_\_\_ Occasionally \_\_\_\_ Moderately

Hours of Sleep: \_\_ 6 \_\_ 8 \_\_ 10 \_\_ More than 10

Well balanced diet: \_\_\_\_ Never \_\_\_\_ Rarely \_\_\_\_ Occasionally \_\_\_\_ Moderately

Do you smoke? \_\_ No \_\_ Occasionally \_\_ 1 to 2 \_\_ 2 to 3 \_\_ 3 to 4 \_\_ 4 to 5 \_\_ More than 5packs/day

Do you drink caffeinated beverages? \_\_ No \_\_ Occasionally \_\_ 1 to 2 \_\_ 2 to 3 \_\_ 3 to 4 \_\_ 4 to 5 \_\_ More than 5 drinks/day

Do you drink alcoholic beverages? \_\_ No \_\_ Occasionally \_\_ 1 to 2 \_\_ 2 to 3 \_\_ 3 to 4 \_\_ 4 to 5 \_\_ More than 5 drinks/day

Have you ever used street drugs? \_\_\_\_\_ YES \_\_\_\_\_ NO

Hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient history was obtained from: \_\_\_\_\_ Patient \_\_\_\_\_ Father \_\_\_\_\_ Mother \_\_\_\_\_ Son \_\_\_\_\_Daughter

Notes / Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Doctor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_