CONFIDENTIAL PATIENT CASE HISTORY

Name _____ Birthday _____ Sex ☐ M ☐ F

Address _____ City/State _____ Zip _____

Soc. Sec. # _____Cell _____ E-Mail _____

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

Occupation _____ Employer _____

Emergency Contact _____ Relationship _____ Phone Number _____

Who referred you to us? _____ How else did you hear about us? _____

HISTORY OF CURRENT SYMPTOMS

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? _____

MARK YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT.
Use the following Symbols:

Aches XXXX Numbness OOOO Pins/Needles •••• Stabbing ////

MARK AN "X" ON THE LINES BELOW:

How bad are your symptoms now?

None ---------- Most Severe

How bad have they been in the past?

None ---------- Most Severe

Frequency: ☐ Occassional (0-25%) ☐ Intermittent (25-50%)
☐ Frequent (50-75%) ☐ Constant (75-100%)

Signature _____ Date _____

Patient Name_____ Date_____

HEALTH HISTORY Check only the ones you now have or have had in the past.

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

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

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

Contraception Type _____
Age at First Period _____
No. of Pregnancies _____
No. of Births _____
No. of Miscarriages _____
No. of Abortions _____
Last Period _____
Last Pap Smear _____
Last Mammogram _____
Last Prostate Exam _____

Patient Name_____ Date_____

HEALTH HISTORY Check only the ones you now have or have had in the past.

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

PSYCHIATRIC	NOW	PAST
Hyperventilation	☐ N	☐ P
Insecurity	☐ N	☐ P
Depression	☐ N	☐ P
Trouble Sleeping	☐ N	☐ P
Irritable	☐ N	☐ P
Timid	☐ N	☐ P
Hallucinations	☐ N	☐ P
Loss of Memory	☐ N	☐ P
Alcoholism	☐ N	☐ P
Drug Addiction	☐ N	☐ P
Suicidal Thoughts	☐ N	☐ P
Extreme Worry	☐ N	☐ P
Sexual Problems	☐ N	☐ P

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

ENDOCRINE	NOW	PAST
Weight Loss	☐ N	☐ P
Weight Gain	☐ N	☐ P
Extremely Thin	☐ N	☐ P
Heat Intolerance	☐ N	☐ P
Cold Intolerance	☐ N	☐ P
Hair Changes	☐ N	☐ P
Breast Changes	☐ N	☐ P

IMMUNIZATION/VACCINATION

DPT	☐ Y
Mumps	☐ Y
Smallpox	☐ Y
Typhoid	☐ Y
Tetanus	☐ Y
Measles	☐ Y
Pneumococcal	☐ Y
Influenza	☐ Y
Polio	☐ Y
MMR	☐ Y

BLOOD TYPE

A+ ☐	A- ☐
B+ ☐	B- ☐
AB+ ☐	AB- ☐
O+ ☐	O- ☐

Other_____

BLOOD TRANSFUSIONS
Date_____
Date_____
Date_____

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

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

Date of Last Chest X-Ray _____ ☐ Normal ☐ Abnormal
Date of Last TB Skin Test _____ ☐ Normal ☐ Abnormal
Allergies _____
_____
_____
_____

Patient Name_____ Date_____

HEALTH HISTORY

List any surgical operation and years: _____

_____

List any hospitalization 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

If yes, describe: _____

FAMILY HISTORY List any of the conditions previously listed which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses/Conditions
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Mat. Grandfather	_____	_____	_____	_____	_____
Mat. Grandmother	_____	_____	_____	_____	_____
Pat. Grandfather	_____	_____	_____	_____	_____
Pat. Grandmother	_____	_____	_____	_____	_____

SOCIAL HISTORY Check the boxes and fill in accordingly.

Height _____ Weight _____ lbs. 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 day _____

Smoking ☐ Current ☐ Previous Packs/Day _____ No. of Years _____

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

Caffeine Cups/Day _____ No. of Years _____

Aspirin No./Day _____ No. of Years _____