Case History Form

(Please fill out both sides)

Date:___/___/_____ Patient Name:_____

GENERAL
1_____ Fever
2_____ Chills
3_____ Night Sweats
4_____ Loss of Sleep
5_____ Fatigue
6_____ Nervousness
7_____ Weight Loss or Gain
8_____ Allergies
9_____ Bleeding Problem
10____ Anemia
11____ Diabetes
12____ Cancer
13____ Heart Disease
14____ Asthma
15____ HIV Risk Factors
(Sharing needles, etc...)

EYE, EAR, NOSE and THROAT
16____ Poor Vision
17____ Pain in Eye(s)
18____ Deafness/Difficulty Hearing
19____ Nosebleeds
20____ Nose Problems
21____ Sinus Trouble
22____ Dental Problems
23____ Hoarseness
24____ Tonsillectomy

GASTROINTESTINAL
25____ Poor Appetite
26____ Poor Digestion
27____ Difficulty Swallowing
28____ Belching or Gas
29____ Frequent Nausea
30____ Vomiting
21____ Vomiting Blood
32____ Pain over Abdomen
33____ Ulcer
34____ Black or Bloody Stool
35____ Liver Problems
36____ Gall Bladder Problems
37____ Jaundice
38____ Hernia
39____ Diarrhea
40____ Constipation
41____ Hemorrhoids
42____ Appendicitis

RESPIRATORY
53____ Difficulty Breathing
54____ Chronic Cough
55____ Spitting Blood
56____ Spitting Phlegm
57____ Wheezing
58____ Pneumonia
59____ Tuberculosis

CARDIOVASCULAR
60____ Irregular Heartbeat
61____ High Blood Pressure
62____ Pain over Heart
63____ Previous Heart Trouble

CARDIOVASCULAR CONT.
64____ Ankle Swelling
65____ Varicose Veins
66____ Rheumatic Fever
67____ Stroke

GENITOURINARY
68____ Frequent Urination
69____ Painful Urination
70____ Blood in Urine
71____ Kidney Disease
72____ Urinary Infection
73____ Inability to Control Urination
74____ Difficulty Starting Urine Flow
75 Get up ___ times per night to urinate
76____ Venereal Infection (STD)
77____ Sexual Difficulties

SKIN
78____ Itching
79____ Bruising
80____ Change in Mole(s)
81____ Skin Cancer
82____ Eczema
83____ Psoriasis
84____ Other Skin Lesions

NEUROLOGICAL
85____ Weakness
86____ Twitching
87____ Tremors
88____ Headache
89____ Fainting
90____ Dizziness
91____ Convulsions
92____ Epilepsy
93____ Numbness/Tingling
94____ Arm/Leg Pain
95____ Mental Disorder

ENDOCRINE
96____ Goiter
97____ Thyroid Cancer
98____ Adrenal Disease
99____ Diabetes (Indicate type I or II)

ACCIDENTS/TRAUMA
100___ Motor Vehicle Accidents
101___ Other Trauma/Accidents

WOMEN ONLY
102___ Live Births
103___ Miscarriages
104___ Painful Periods
105___ Excessive Flow
106___ Irregular Cycles
107___ Vaginal Burning/Itching
108___ Hot Flashes
109 Date Last Period Began _____

MEN ONLY
110___ Testicular Swelling/Pain
111___ Prostate Problem

IMMUNE SYSTEM
112___ Auto Immune Disease
113___ Getting Sick Very Easily
114___ Leukemia/Lymphoma

MUSCULOSKELETAL
115___ Neck Stiffness/Pain
116___ Pain Between Shoulders
117___ Low Back Pain
118___ Swollen Joints
119___ Painful Joints
120___ Muscle Aches/Soreness
121___ Spinal Curvature
122___ Arthritis

CHILDHOOD DISEASES
123___ Mumps
124___ Measles
125___ Chickenpox

HOSPITALIZATIONS
126___ List Dates and Reasons:
_____
_____
_____
_____

SURGERIES
127___ List Dates and Reasons:
_____
_____
_____

HABITS
128___ Smoking _____ packs/day
129___ Drinking
130___ Recreational Drug Use

FAMILY HISTORY
Use the following abbreviations:
M=Mother **F**=Father **S**=Sister **B**=Brother
MM=Mother's Mother **MF**=Mother's Father
FM=Father's Mother **FF**=Father's Father

131_____ Diabetes
132 _____Thyroid Dz
133_____ Tuberculosis
134_____ Kidney Dz
135_____ High Blood Press.
136_____ Heart Disease
137_____ Muscle, Bone, or Nerve Disease
138_____ Other

VACCINATIONS (Please use MM/YYYY)
_____ Tetanus/DPT
_____ Influenza
_____ Pneumovax

PRIMARY CARE PHYSICIAN
Name and phone number
_____
_____

The items above may relate to your current condition. In the space in front of each item, place a P if you PRESENTLY have the problem and an H if you previously HAD the problem. Leave the space blank if you NEVER had the problem.

Case History Form

Date:___/___/_____ Patient Name:_____

General Health _____
Childhood Illnesses _____
_____
Major Adult Illnesses _____
Serious Injuries & Resulting Disability _____
Allergies _____
Recent Screening Tests _____
Primary Care Physician and Any Specialists Consulted _____
_____

Medication List - Include over the counter medications

1. _____ Dosage _____ Frequency _____ Reason for taking _____
2. _____ Dosage _____ Frequency _____ Reason for taking _____
3. _____ Dosage _____ Frequency _____ Reason for taking _____
4. _____ Dosage _____ Frequency _____ Reason for taking _____
5. _____ Dosage _____ Frequency _____ Reason for taking _____
6. _____ Dosage _____ Frequency _____ Reason for taking _____
7. _____ Dosage _____ Frequency _____ Reason for taking _____

Others _____
_____
_____

Supplements/Vitamins/Herbs List

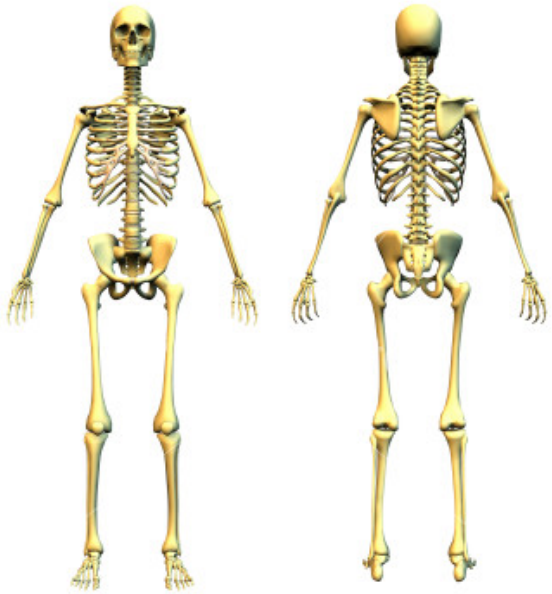
1. _____ Dosage _____ Frequency _____ Reason for taking _____
2. _____ Dosage _____ Frequency _____ Reason for taking _____
3. _____ Dosage _____ Frequency _____ Reason for taking _____
4. _____ Dosage _____ Frequency _____ Reason for taking _____
5. _____ Dosage _____ Frequency _____ Reason for taking _____
6. _____ Dosage _____ Frequency _____ Reason for taking _____
7. _____ Dosage _____ Frequency _____ Reason for taking _____

Others _____
_____
_____

Known Allergies _____
_____

Pain Chart

Front **Back**



Please mark areas affected on this diagram, using the following abbreviations:

P=Pain
R=Radiation
N=Numbness
T=Tingling
S=Soreness
A=Ache
St=Stiffness(ST)

I hereby attest that the foregoing information is true and correct to the best of my knowledge, and that I have not knowingly omitted any prescription, street, or over the counter medication, supplements, or vitamins from this case history form.

Patient Signature: _____ **Date:** _____