



Name _____ Birthdate: _____ Date _____

Dominant Hand Right Left Marital Status (Check One) Single Divorced Widow Married
 Occupation _____ Date symptoms began _____

Referring physician _____

List current symptoms _____

What treatment, if any, have you had for these symptoms? _____

Were you in an accident? Yes No If yes, what date? _____

What type of accident? _____

What treatment did you receive for this? Was there a hospitalization?

What makes the pain better? _____

What makes the pain worse? _____

MEDICAL HISTORY/REVIEW OF SYSTEMS

<u>Disease or Disorder</u>	You	Family	<u>Disease or Disorder</u>	You	Family
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Vein Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Bowel	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Other Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Hypothermia	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Anesthesia Problems	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Other Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Tingling	<input type="checkbox"/>	<input type="checkbox"/>

List all past operations, serious illnesses & hospitalizations, including dates:

_____ year: _____
 _____ year: _____



_____ year: _____

List any **ALLERGIES** to medication, food, or **LATEX** and the reaction they cause

Medication	Reaction

List all medications you are currently taking. Please indicate dosage, times per day and reason for the medication. If none at this time, please state "None". Please include over the counter medications and herbal medications in this list:

Medication	Strength/Dosage	How do you take it?	How often?

Do you use alcohol Yes No What type? _____ How often? _____

Do you use tobacco Yes No What type? _____ How often? _____

Family History

Father Living? Yes No Siblings Living? Yes No

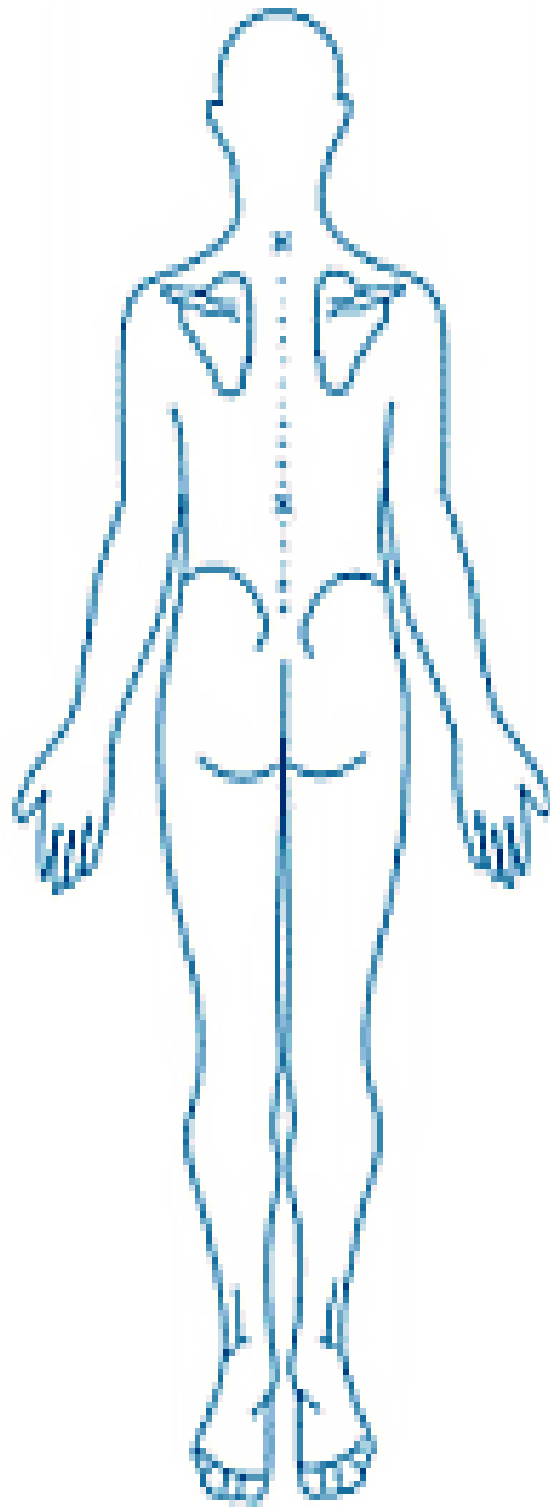
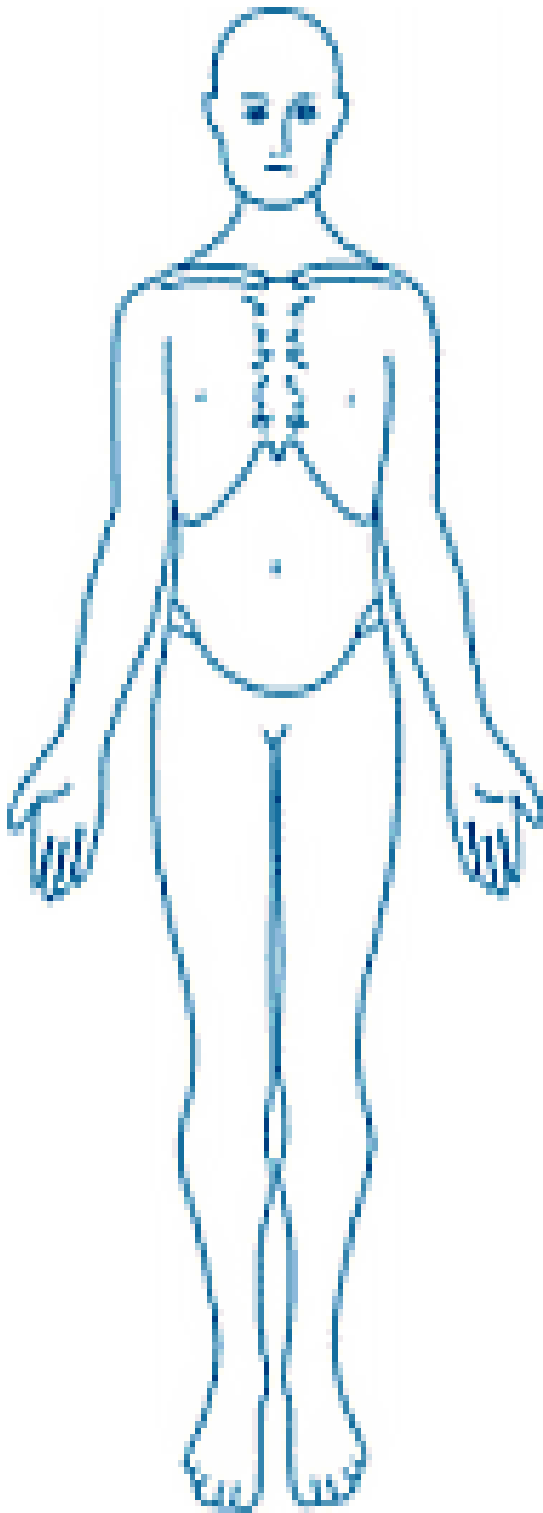
Children Living? Yes No Mother Living? Yes No

Are you taking any blood thinners? (Ex: Lovenox, Warfarin, Aggrenox, Plavix, Coumadin etc.)



Name _____ Birthdate: _____ Date _____

Using
areas
pain,



the
diagram,
identify all
that have
numbness,
and/or
tingling.