Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Patient History

Please answer every question

STAFF: Handwritten responses must be entered **MANUALLY**.

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

What is the reason for today's visit? _____

What is your height?

Feet	3 ○	4 ○	5 ○	6 ○	7 ○						
Inches	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○	10 ○	11 ○

What is your weight?

	100 ○	200 ○	300 ○	400 ○	500 ○	600 ○			
Pounds	10 ○	20 ○	30 ○	40 ○	50 ○	60 ○	70 ○	80 ○	90 ○
	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○

Are you: right handed ○ left handed ○ ambidextrous ○

please fold on dotted line

Current severity of symptom(s) on a scale of 0 – 10 *(0 = least painful 10 = most painful)*

☺ No Pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ☹ Most Painful

Have you ever had problems with anesthesia? *(i.e. high fever, malignant hyperthermia)* yes ○ no ○

MEDICATIONS

Please list all medications you are currently taking.

Include prescriptions (pills, inhalers, creams, shots), over the counter medication (aspirin, antacids, etc.), vitamins and supplements (fish oil, etc). Include medications that you use only as needed.

Name of Medication	Dosage	Frequency	Name of Medication	Dosage	Frequency

please fold on dotted line

Pharmacy name, address and phone number: _____

_____

ALLERGIES

Please indicate if you have allergies to any of the following by writing "yes" or "no" on the provided lines.

I HAVE NO KNOWN ALLERGIES_____

penicillin_____ erythromycin_____ cipro_____
contrast dye_____ sulfa_____ ibuprofen_____ latex_____
iodine_____ aspirin_____ bacitracin_____

other *(please specify)*: _____

Race: American Indian or Alaska Native_____ Black or African American_____ White_____
Asian_____ Native Hawaiian or Other Pacific Islander_____

Ethnicity: Hispanic or Latino_____ not Hispanic or Latino_____

Preferred language: English_____ Japanese_____ Italian_____ Other_____
French_____ Korean_____ Spanish_____

Email address: _____

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SOCIAL HISTORY

What is your occupation? _____

What is your marital status? single ◯ domestically partnered ◯ divorced ◯ married ◯ separated ◯ widowed ◯

Please describe your cigarette smoking status. currently (every day) ◯ in the past ◯ current status unknown ◯ currently (some days) ◯ never ◯ unknown if ever smoked ◯

How many packs per day? *(now or in the past)* ½ ◯ 1 ◯ 1½ ◯ 2 ◯ >2 ◯

Counseled to quit smoking? yes ◯ no ◯

Do you drink alcohol? yes ◯ no ◯ in the past ◯

If yes, how many drinks per week? occasionally ◯ 1-3 ◯ 4-7 ◯ 8-14 ◯ >14 ◯

How often do you exercise? never ◯ rarely ◯ 1-3 times / wk ◯ 3-5 times / wk ◯ daily ◯

Have you ever been addicted to or dependent on drugs or pain medication? yes ◯ no ◯

Do you take any pain medication? yes ◯ no ◯

Are you on a pain contract? yes ◯ no ◯

YOUR MEDICAL HISTORY

Please indicate if YOU have a history of the following. *(Mark all that apply.)*

please fold on dotted line

- ◯ Diabetes
  - ◯ Insulin Dependent
- ◯ Blood Transfusions
- ◯ Sleep Apnea
  - ◯ C-PAP
- ◯ Chemotherapy / Radiation
- ◯ Hepatitis
- ◯ Head Injury
- ◯ High Blood Pressure
- ◯ Chest Pain
- ◯ Heart Disease
- ◯ Cardiac Stent
- ◯ Implanted Defibrillator
- ◯ Asthma
- ◯ Bronchitis
- ◯ Breast Biopsy
- ◯ Pneumonia
- ◯ COPD
- ◯ Mastectomy
- ◯ Reflux Esophagitis
- ◯ Kidney Problems
- ◯ Chronic UTI
- ◯ Irritable Bowel Syndrome (IBS)
- ◯ Kidney Failure
- ◯ Kidney Transplant
- ◯ Osteoporosis
- ◯ Lupus / SLE
- ◯ Paralysis
- ◯ Epilepsy
- ◯ Alzheimer's Disease
- ◯ Anemia
- ◯ Bleeding Problems
- ◯ Blood Clots
- ◯ Peripheral Vascular Disease
- ◯ Major Injuries
- ◯ Cancer
- ◯ HIV / AIDS
- ◯ Immune System Disorder
- ◯ Eye / Vision Problems
  - ◯ Glaucoma
- ◯ Ear, Nose, Throat Disorder
- ◯ Congestive Heart Failure
- ◯ MRSA
- ◯ Heart Attack
- ◯ Pacemaker
- ◯ Heart Valve Implant
- ◯ Emphysema
- ◯ Tuberculosis (TB)
- ◯ Fibromyalgia
- ◯ Dialysis
- ◯ Kidney Stones
- ◯ Jaundice
- ◯ Rheumatoid Arthritis
- ◯ Gout
- ◯ Stroke
- ◯ Seizure
- ◯ Balance Problems
- ◯ Phlebitis
- ◯ Skin Disorders
- ◯ Osteoarthritis
- ◯ Disc Disease
- ◯ Metal Implant(s) or Fragment(s)
- ◯ Work Related Injury(ies)

please fold on dotted line

◯ **OTHER** *(please specify)*: _____

◯ Motor Vehicle Accident(s)

◯ **NONE**

FAMILY MEDICAL HISTORY

Does any FAMILY MEMBER of yours have a history of any of the following?
(Include only parents, grandparents, siblings, and children.)

- ◯ Alcohol Abuse
- ◯ Anemia
- ◯ Arthritis
- ◯ Asthma
- ◯ Back or Neck Problems
- ◯ Bladder Problems
- ◯ Bleeding Disorders
- ◯ Brain Cancer
- ◯ Breast Cancer
- ◯ Colon Cancer
- ◯ Depression
- ◯ Diabetes
- ◯ Fibromyalgia
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ Kidney Disease
- ◯ Lung / Respiratory Disease
- ◯ Migraines
- ◯ Multiple Sclerosis
- ◯ Osteoporosis
- ◯ Seizures
- ◯ Stroke
- ◯ Surgical Complications
- ◯ Thyroid Problems
- ◯ Other Disease, Cancer, or Medical Illness

◯ **NONE**

REVIEW OF SYMPTOMS

Please mark only the symptoms you CURRENTLY are experiencing.
Mark all that apply. If you have no symptoms in a category, please mark "NONE."

GENERAL
- fever
- weight loss
- weight gain
- persistent infections
- fatigue
- NONE

EYES
- visual disturbances
- glasses / contacts
- NONE

EAR, NOSE, AND THROAT
- hearing loss
- seasonal allergies
- sinus pain
- oral ulcers
- NONE

CARDIOVASCULAR
- difficulty breathing on exertions
- chest pain
- shortness of breath
- palpitations
- swelling hands / feet
- NONE

BREAST
- mass / lump
- breast pain
- nipple discharge
- NONE

please fold on dotted line

RESPIRATORY
- difficulty breathing
- wheezing
- chronic cough
- coughing blood
- NONE

GASTROINTESTINAL
- nausea
- vomiting
- constipation
- chronic diarrhea
- change in bowel habits
- reflux
- hemorrhoids
- abdominal pain
- NONE

FEMALE GENITOURINARY (WOMEN ONLY)
- pelvic pain
- urinary frequency
- excessive urination at night
- urinary urgency
- blood in urine
- urine leakage
- vaginal dryness
- vaginal discharge
- vaginal itch or burning
- painful intercourse
- NONE

MALE GENITOURINARY (MEN ONLY)
- excessive urination at night
- urine leakage
- urinary frequency
- urinary urgency
- impotence
- NONE

MUSCULOSKELETAL
- joint pain
- muscle pain
- muscle weakness
- NONE

SKIN
- dry skin
- rash
- skin ulcer
- NONE

ENDOCRINE
- hair changes
- hot flashes
- cold intolerance
- heat intolerance
- NONE

please fold on dotted line

NEUROLOGIC
- change in taste
- smell
- coordination
- difficulty with speech
- disorientation
- dizziness
- fainting
- headaches
- imbalance
- loss of balance
- falls
- loss of consciousness
- memory loss
- muscle weakness
- numbness
- tingling
- seizures
- stroke
- temporary paralysis
- NONE

PSYCHIATRIC
- change in sleep pattern
- depression
- anxiety
- NONE

HEME / LYMPHATIC
- easy bruising
- excessive bleeding
- gland problems
- NONE

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SURGICAL HISTORY

Please mark all surgeries you have had.

○ I HAVE HAD NO SURGERIES

SPINAL SURGERIES

Other Spinal Surgeries	
Spine Surgery	○
Pain Pump	○
Spinal Stimulator	○
Spinal Tumor	○
Scoliosis Surgery	○
Spine Other	○

(please describe): _____

	CERVICAL	LUMBAR	THORACIC
First Spinal Decompression			
Discectomy	○	○	○
Laminectomy	○	○	○
Fusion	○	○	○
Second Spinal Decompression			
Discectomy	○	○	○
Laminectomy	○	○	○
Fusion	○	○	○
Third Spinal Decompression			
Discectomy	○	○	○
Laminectomy	○	○	○
Fusion	○	○	○

please fold on dotted line

BRAIN SURGERIES

	TUMOR	ANEURYSM	SUBDURAL	STIMULATOR	GAMMA KNIFE
First Brain Surgery	○	○	○	○	○
Second Brain Surgery	○	○	○	○	○

Other Brain Surgery(ies) *(please describe)*: _____

Prostate Surgery	TURP ○	Removal ○		
Gallbladder Surgery	Open ○	Laparoscopic ○		
Lung Surgery	Left ○	Right ○	Both ○	
Transplant	Liver ○	Kidney ○	Cornea ○	
Kidney Removal	Left ○	Right ○	Both ○	
Cataract Surgery	Left ○	Right ○	Both ○	
Breast Cancer Lump Removal	Left ○	Right ○	Both ○	
Mastectomy	Left ○	Right ○	Both ○	
Cosmetic Breast	Left ○	Right ○	Both ○	
Other Cosmetic	Left ○	Right ○	Both ○	
Ovary Removal	Left ○	Right ○	Both ○	
Carpal Tunnel Surgery	Left ○	Right ○	Both ○	
Rotator Cuff Repair	Left ○	Right ○	Both ○	
Arthroscopic Shoulder Surgery	Left ○	Right ○	Both ○	
Hip Fracture & Surgery	Left ○	Right ○	Both ○	

please fold on dotted line

Total Hip Replacement	Left ○	Right ○	Both ○	
Total Knee Replacement	Left ○	Right ○	Both ○	
Arthroscopic Knee Surgery	Left ○	Right ○	Both ○	
Hand Surgery	Left ○	Right ○	Both ○	
Foot Surgery	Left ○	Right ○	Both ○	
Leg Circulation Surgery	Left ○	Right ○	Both ○	
Thyroid Surgery	Left ○	Right ○	Total ○	Partial ○
Carotid Artery Surgery	Left ○	Right ○	Both ○	Multiple times ○
Inguinal Hernia Surgery	Left ○	Right ○	Both ○	Multiple times ○
Caesarean Section	1 ○	2 ○	3 or more ○	
Heart Bypass Surgery	Angioplasty ○	Ablation ○	Stent ○	
Weight Loss Surgery	Bypass ○	Banding ○		

Heart Valve Replacement ○ Appendectomy ○
Hemorrhoidectomy ○ Tonsillectomy ○
Vasectomy ○