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CASE HISTORY

Answers to the following questions may be helpful in diagnosing and managing your health problems. Your answers are confidential. Please feel free to provide any additional details. Thank you for your efforts.

Patient Name ______________________________ Date Completed ________________
Age_______ Date of Birth_____________ Gender: M F Marital Status: M S D W
Primary Care Physician __________________________ Referring Physician __________________
Occupation ______________________________ Height ____________ Weight __________

What is the main reason for today's visit? ______________________________
Where is the pain/problem? ______________________________
Was this caused by a specific injury? Yes_______ No_____
Describe the cause of the problem ______________________________
When did symptoms begin? ______________________________
Describe the pain (throbbing, stabbing, achy, etc.) ______________________________
When does the pain occur? ______________________________
Severity of the pain on a scale of 1 to 10? (10 most severe) ______________________________
Activity or motion associated with pain? ______________________________
What medications have you taken in the past for this pain? ______________________________
Is there anything you can do to make it better? ______________________________
What recreational activities do you enjoy? ______________________________
Is this worker compensation? Yes_______ No_____ (If no, skip to next section)

Date of onset___________________________
Are you presently working? Yes_______ No_____
If yes, are you on modified duty? Yes_______ No_____
If yes, list restrictions____

PAST MEDICAL HISTORY (Circle YES or NO for any problems which apply to you)

Anemia	YES	NO
Asthma/Bronchitis/Emphysema	YES	NO
Arthritis	YES	NO
Bleeding disorder	YES	NO
Cancer (type)	YES	NO
Diabetes (insulin dependent)	YES	NO
Diabetes (non-insulin dependent)	YES	NO
Heart Problems	YES	NO
Hepatitis/Liver Disease	YES	NO
High Blood Pressure	YES	NO
Immune Disorder	YES	NO
Kidney Problems	YES	NO
Stomach/Intestinal Problems, Ulcers	YES	NO
Stroke	YES	NO

Other (please describe) ______________________________

Continued on next page…

List previous hospitalizations, ALL surgeries, serious injuries, and approximate dates:

Current Medications:

Allergies:

Does anyone in your family have significant health problem? (Please describe)

Do you (or did you in the past) use tobacco? YES NO

Cigarettes: Packs/day_____ Years?____ If you quit, when?________________________________

Other tobacco use?____

Do you drink alcohol? YES NO How often, how much?____

Do you use any drugs other than prescribed or over-the-counter medications? YES NO

If so, please list____

EXTENDED REVIEW OF SYSTEMS

Do you presently have any problems or symptoms in any of the following areas?
Circle Y = Yes or N = No below. If "Yes", give an explanation.

	Yes	No	Patient Comments:	Physician Comments:
CONSTITUTIONAL				
Good general health lately	Y	N		
Recent weight changes	Y	N		
Recurrent fevers, chills, sweats	Y	N		
Fatigue	Y	N		
EYES				
Wear glasses/contact lenses	Y	N		
Blurred or double vision	Y	N		
Change in vision	Y	N		
Glaucoma	Y	N		
EARS / NOSE MOUTH / THROAT				
Change in hearing	Y	N		
Ringing in the ears	Y	N		
Recent nose bleeds	Y	N		
Chronic sinus problems	Y	N		
Mouth sores	Y	N		
Bleeding gums	Y	N		
Frequent sore throats	Y	N		
Voice changes	Y	N		
RESPIRATORY				
Asthma or wheezing	Y	N		
Breathing problems	Y	N		
Coughing up blood	Y	N		
Chronic cough	Y	N		
Pneumonia	Y	N		
CARDIOVASCULAR				
Heart trouble or heart attack	Y	N		
Chest pain or angina	Y	N		
Shortness of breath	Y	N		
Palpitations	Y	N		
Swelling of feet, ankles or hands	Y	N		
Blood clots	Y	N		
Varicose veins	Y	N		
GASTROINTESTINAL				
Change in appetite	Y	N		
Severe heartburn	Y	N		
Bleeding ulcers	Y	N		
Frequent nausea/vomiting	Y	N		
Vomiting blood	Y	N		
Frequent diarrhea	Y	N		
Constipation/painful bowel movements	Y	N		
Black or bloody stools	Y	N		
Rectal bleeding	Y	N		
Abdominal pain	Y	N		

	Yes	No	Patient Comments:	Physician Comments:
GENITOURINARY				
Blood in the urine	Y	N		
Burning with urination	Y	N		
Change in force of stream when urinating	Y	N		
Sexually transmitted disease	Y	N		
Change in sexual function or interest	Y	N		
Prostate trouble (men)	Y	N		
Scrotal masses (men)	Y	N		
Abnormal uterine bleeding (women)	Y	N		
Uterine tumors (women)	Y	N		
Pain/problems with periods (women)	Y	N		
NEUROLOGICAL				
Headaches	Y	N		
Numbness or tingling sensations	Y	N		
Weakness or paralysis	Y	N		
Convulsions or seizures	Y	N		
Change in memory or concentration	Y	N		
INTEGUMENTARY (Skin & Breasts)				
Birth marks	Y	N		
Recurrent rashes	Y	N		
Changing moles	Y	N		
Skin cancer or melanoma	Y	N		
Non-healing wounds	Y	N		
Breast pain or lump	Y	N		
Change in hair or nails	Y	N		
PSYCHIATRIC				
Memory loss or confusion	Y	N		
Nervousness	Y	N		
Depression	Y	N		
Change in sleep	Y	N		
Other	Y	N		
MUSCULOSKELETAL				
Joint stiffness or pain	Y	N		
Muscle pain or cramping	Y	N		
Weakness of muscles or joints	Y	N		
Back pain	Y	N		
Difficulty walking	Y	N		
ENDOCRINE				
Heat or cold intolerance	Y	N		
Excess thirst or urination	Y	N		
Thyroid problems	Y	N		
ALLERGIC / IMMUNOLOGIC				
Low resistance to infection	Y	N		
Recent cold or flu	Y	N		
Environmental allergies	Y	N		
Allergic reaction to medication	Y	N		
Tetanus booster within past 10 years	Y	N		
Other immunizations up to date	Y	N		
HEMATOLOGIC / LYMPHATIC				
Easy bruising	Y	N		
Frequent bleeding	Y	N		
Enlarged lymph nodes	Y	N		