



Date: \_\_\_\_\_

Name: \_\_\_\_\_

**CURRENT MEDICATIONS:** (List all current medications not just those for back problems)

Name	Dosage	Physician Name	How long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PAST MEDICAL HISTORY:**    **Check all that apply**                       None Apply

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Rheumatoid arthritis  | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Heart failure       | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Osteoarthritis        | <input type="checkbox"/> ADHD              |
| <input type="checkbox"/> Abnormal heartbeat  | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Gout                  | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid        | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Migraine          |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Cirrhosis             | <input type="checkbox"/> Cerebral palsy    |
| <input type="checkbox"/> Blood clots in leg  | <input type="checkbox"/> Gastric reflux | <input type="checkbox"/> Hepatitis (A, B or C) | <input type="checkbox"/> Downs syndrome    |
| <input type="checkbox"/> Blood clots in lung | <input type="checkbox"/> Hiatal hernia  | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Spina bifida      |
| <input type="checkbox"/> Poor circulation    | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Bleeding disorder     | <input type="checkbox"/> Neurofibromatosis |
| <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Kidney stones  | <input type="checkbox"/> Anemia                |  |
| <input type="checkbox"/> Neuropathy:         | <input type="checkbox"/> Hands or       | <input type="checkbox"/> Feet                  |  |

Cancer: \_\_\_\_\_ (type/treatment)

Diabetes: year diagnosed \_\_\_\_\_

Currently controlled with     insulin                       oral medications                       diet

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES :**

(please specify type of reaction i.e. anaphylaxis, intolerance, childhood allergy, swelling, rash, itching)

Agent/Substance

Type of Reaction

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**SURGICAL HISTORY:**

No Prior Surgery

Surgical Procedure

Year

Surgeon

Hospital

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**HOSPITALIZATIONS:**

Surgical Procedure

Year

Physician

Hospital

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**FAMILY HISTORY:**

Father	Living/Deceased	Cause of Death _____	Age _____
Mother	Living/Deceased	Cause of Death _____	Age _____
Brother(s)	Living/Deceased	Cause of Death _____	Age _____
Sister(s)	Living/Deceased	Cause of Death _____	Age _____

Please mark the following if found in the family:

	Mother	Father	Brother	Sister
Hypertension	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Breast Cancer	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
Lung Cancer	_____	_____	_____	_____
Colon Cancer	_____	_____	_____	_____
Heart Attack	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____
Asthma	_____	_____	_____	_____

**SOCIAL HISTORY:**

Alcohol use: Y N \_\_\_\_ # drinks/day \_\_\_\_ # drinks/week  
Tobacco use: Y N \_\_\_\_ # packs/day \_\_\_\_ # years Ceased smoking \_\_\_\_ years ago

Marital Status: Married Single Divorced Separated Widowed  
Number of children: \_\_\_\_

Occupation/Work: \_\_\_\_\_  
Currently Disabled Y N N/A  
Retired Y N  
Homemaker Y N

Education Completed: GED high school college graduate school  
Highest Grade Completed \_\_\_\_\_

**REVIEW OF SYSTEMS: Check all that apply**

*Constitutional:*

- In good general health
- Appetite problems
- Fatigue
- Fever
- Weight gain
- Weight loss

*Skin:*

- Bruising
- Changes in moles
- Pain
- Rashes
- Redness
- Ulcers
- Wound healing (slow)
- Varicose veins

*Eyes:*

- Blurred vision
- Difficulty seeing
- Double vision
- Glasses
- Contacts
- Surgical correction
- Tears
- Cataracts

*Ears/Nose/Throat:*

- Deafness
- Dental problems
- Dizziness
- Headaches
- Hearing changes
- Hoarseness
- Mouth sores
- Nasal congestion
- Nose bleeds
- Sore throat

*Cardiovascular:*

- Chest pain
- Extra heart beats
- Irregular heart rate
- Palpitations
- Claudication

*Respiratory:*

- Bloody cough
- Cough
- Shortness of breath
- Sputum
- Wheezing

*Gastrointestinal:*

- Abdominal pain
- Constipation
- Diarrhea
- Heart burn
- Irritable bowel
- Nausea
- Rectal bleeding
- Ulcers
- Vomiting
- Change in bowel habits
- Bowel incontinence

*Genitourinary:*

- Blood in urine
- Discharge
- Frequency of urination
- Bladder incontinence
- Hesitancy of urination
- Kidney stones
- Painful urination
- Prostate problems
- Urinary tract infections
- Change in force when urinating

*Musculoskeletal:*

- Muscle weakness
- Neck pain
- Numbness
- Spine pain radiating to arms
- Spine pain radiating to legs
- Sprains
- Stiffness
- Strains
- Swollen joints
- Tingling
- Arthritis
- Difficulty walking
- Deformities

*Neurologic:*

- Balance problems
- Headaches
- Memory loss
- Migraines
- Seizures
- Strokes
- Mini stroke
- Tremors
- Concussion

*Psychiatric:*

- Anxious
- Depressed
- Hallucinations
- Sleep disturbances
- Confusion

*Endocrine:*

- Excessive thirst
- Excessive urination
- Growth abnormalities
- Heat/cold intolerance
- High blood sugar
- Low blood sugar
- Insulin resistance

*Lymphatics:*

- Anemia
- Bleeding tendencies
- Enlarged lymph nodes
- Blood clots
- Clotting problems

*Allergic/Immunologic*

- Eczema
- Hives
- Persistent itching