

Medical History

Patient Name _____ Date _____ Primary Care Physician _____

Allergies _____

Current Medications _____

Check those conditions that apply to you:

- | | |
|---|--|
| <input type="radio"/> Heart Disease | <input type="radio"/> Depression |
| <input type="radio"/> Respiratory Disease | <input type="radio"/> Alcohol abuse history |
| <input type="radio"/> Diabetes – <i>Taking insulin? Yes / No</i> | <input type="radio"/> Drug abuse history |
| <input type="radio"/> Seizure Disorder – <i>Date of last seizure</i> _____ | <input type="radio"/> Smoker <i>How much?</i> _____ <i>How many years?</i> _____ |
| <input type="radio"/> CVA (<i>Cerebrovascular accident or stroke</i>) <i>Date</i> _____ | <input type="radio"/> Cancer <i>What Type?</i> _____ |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Infectious Disease <i>Explain</i> _____ |
| <input type="radio"/> Current pregnancy <i>Due Date</i> _____ | <input type="radio"/> Other _____ |
| <input type="radio"/> Dizziness / Fainting / Nausea (<i>please circle</i>) | |
| <input type="radio"/> Recent Surgeries <i>Type/Date</i> _____ | |

Please describe your current symptoms:

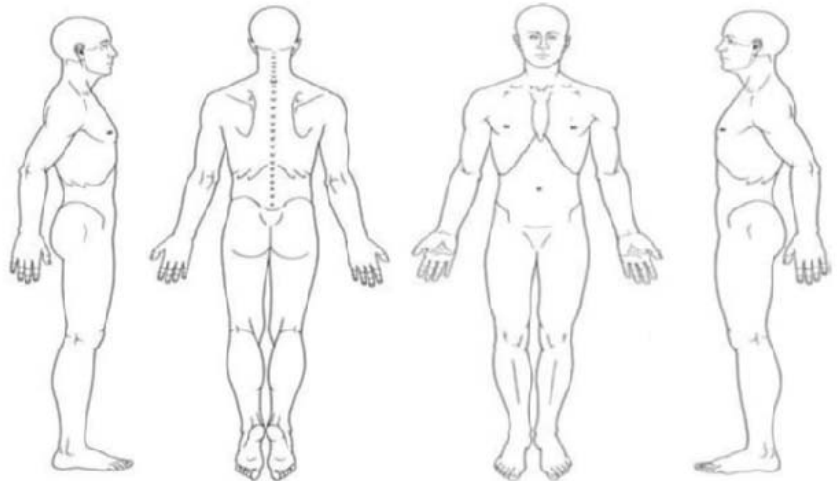
How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50 % of the day)
- Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms.

What describes the nature of your symptoms?

- | | |
|---------------------------------|--------------------------------|
| <input type="radio"/> Sharp | <input type="radio"/> Shooting |
| <input type="radio"/> Dull ache | <input type="radio"/> Burning |
| <input type="radio"/> Numb | <input type="radio"/> Tingling |



How are your symptoms changing?

- Getting better-
- Not changing
- Getting worse

During the past 4 weeks

- Please indicate on the line where your pain is in relation to the 2 extremes

No pain

Worst Pain

- How much has pain interfered with your normal work activities?

Not at all A little bit Moderately Quite a bit Extremely

- How much has pain interfered with your normal daily living activities?

Not at all A little bit Moderately Quite a bit Extremely

Patient Signature _____ Date _____