Medical History

Date of visit: _____

Patient name:_____Weight: _____ Height: _____

What is the reason for your visit: _____

What is your pain level on a scale of 0-10: **0 1 2 3 4 5 6 7 8 9 10** Was your pain caused by an injury: **Yes No**

If yes, when was the injury: _____

Please describe the location of your pain:_____

Your pain is: **Sharp Dull Burning Aching Stinging Throbbing Numbness Tingling**

When did your pain first begin: _____Did it start suddenly: **Yes No**

How often do you have pain: **Constantly Frequently Intermittently Occasionally Rarely Daytime Nighttime**

Severity of your pain: **Mild Moderate Severe** Is your pain: **Improving Unchanged Worsening**

What makes your pain worse: _____What helps your pain: _____

What does your pain keep you from doing: _____

What tests have you had done regarding your pain: _____

What treatments have you received for your pain: (Medications, injections, therapy, etc) _____

_____

Please list all health problems: _____

_____

List any surgeries:_____

List family medical history: _____

Are you currently working: **Yes No** If yes, what is your job: _____

If not, why: **Retired Student Disabled** Are you seeking disability:_____

Do you smoke: **Yes No** If yes, how long and how many per day: _____

Do you drink alcohol: **Yes No** If yes, how often:_____

Have you ever used any illegal drugs**: Yes No** If yes, describe:_____

Do you or your family have any history of addiction:_____

Please list all medications you are currently taking: _____

_____

List any allergies:_____

Review of Systems (Please circle all that apply)

Constitutional	Eyes	Ear/Nose/Throat	Skin
Chills	**Eye pain**	**Difficulty swallowing**	**Rash**
Fever	**Eye discharge**	**Nose bleeds**	**Skin changes**
Weight loss	**Vision loss**	**Hearing loss**	**Lesions/Incisions**
Fatigue	**Visual disturbance**	**Neck swelling**	**Itching**
Difficulty sleeping		**Vertigo**	**Excessive sweating**
Weakness			

Cardiovascular	Respiratory	Gastrointestinal	Psychiatric
Chest pain	**Cough**	**Nausea**	**Depression**
Palpitations	**Shortness of breath**	**Vomiting**	**Anxiety**
Pain in legs with walking	**Coughing up blood**	**Diarrhea**	**Panic attacks**
Swelling		**Constipation**	**Suicidal thoughts**
		Abdominal pain	**Suicidal planning**
			Substance abuse
			Insomnia
			Inability to concentrate

Musculoskeletal		Neurological
Neck pain	**Elbow pain**	**Headaches**
Back pain	**Wrist pain**	**Weakness**
Muscle pain	**Hand pain**	**Numbness**
Joint pain	**Hip pain**	**Confusion**
Joint swelling	**Leg pain**	**Memory loss**
Joint redness	**Knee pain**	**Seizure**
Joint popping	**Foot pain**	**Abnormal walking**
Shoulder pain	**Ankle pain**	**Radiating pain to arms or legs**
Arm pain		**Aura**