Required for Your Case History File - All Information Is Confidential

Full Legal Name_____ Name you prefer_____

Mailing Address_____ City_____

State_____ Zip Code_____ Home Phone _____

☐Female ☐Male Years of education _____ Work Phone _____

Age_____ Date of Birth _____ Cell Phone _____

Occupation_____ Email _____

Employer_____ Work address _____

☐Single ☐Married ☐Widowed ☐Divorcced ☐Separated ☐Partner Number of Children _____

Who referred you to our office? _____

Name of Spouse/Partner _____

Spouse/Partner Cell # _____ Spouse/PartnerWork # _____

Your Emergency Contact _____ Phone_____

Who is your primary care physician? _____

Last Physical Examination_____ Have you been treated for any health condition by a physician in the last year? ☐Yes ☐No If yes, explain_____

_____

_____

Current medications: If not taking any medication, check here: ☐

_____

_____

Current vitamins/herbs/supplements: If not taking any, check here: ☐

_____

_____

Are you allergic to any medications: ☐Yes ☐No If yes, list _____

Previous serious illness/hospitalization (date and describe) _____

_____

_____

Have you ever had: Surgery/Hospitalization ☐Yes ☐No Fractures ☐Yes ☐No

Car Accidents ☐Yes ☐No Falls ☐Yes ☐No On-Job Injury ☐Yes ☐No

Describe: _____

_____

_____

Family history of: Heart disease ☐Yes ☐No Cancer ☐Yes ☐No Diabetes ☐Yes ☐No

Arthritis ☐Yes ☐No Back Problems ☐Yes ☐No Other_____

If you are female, are you possibly pregnant? ☐Yes ☐No Date of last menstrual period: _____

Major Symptom/Problem for this visit: _____

Date symptoms began: _____

How did your first symptoms first begin: _____

_____

_____

Other symptoms: _____

_____

Pain is: ☐Constant ☐Intermittent Is your condition getting ☐worse ☐better ☐staying the same

What activities aggravate your condition? _____

What activities lessen your symptoms? _____

Is this condition worse during certain times of the day? ☐Yes ☐No

Is this condition interfering with work? ☐Yes ☐No With sleep? ☐Yes ☐No With routine? ☐Yes ☐No

Other doctors seen for this condition: _____

_____

_____

List home remedies tried: _____

_____

_____

Do now have any of the following?

Constitutional
____ Unexplained weight loss
____ Fatigue or weakness
____ Fever

Eyes
____ Glaucoma
____ Cataracts
____ Double vision

Ears, nose, throat
____ Difficulty hearing
____ Buzzing or ringing in ears
____ Dizziness
____ Loss of smell
____ Sinus trouble
____ Difficulty swallowing
____ Loss of taste

Skin
____ Rashes
____ Hives
____ Itching

Allergic/Immunologic
____ Hives/hay fever

Respiratory
____ Cold/flu/cough
____ Coughing blood
____ Wheezing

Gastrointestinal
____ Nausea or vomiting
____ Constipation
____ Diarrhea
____ Digestive problems

Genitourinary
____ Blood in urine
____ Bladder leakage
____ Burning/frequent urination

Musculoskeletal
____ Spinal pain
____ Joint swelling
____ Joint stiffness

Cardiovascular
____ Chest pain
____ Shortness of breath
____ Racing heartbeat
____ Fainting spells

Neurological
____ Headaches
____ Memory loss
____ Tremors
____ Numbness
____ Loss of strength
____ Seizures

Mental status
____ Anxiety/depression
____ Mood swings
____ Difficulty sleeping
____ Stress

Endocrine
____ Loss of hair
____ Heat/cold intolerance
____ Diabetes
____ Excessive sweating
____ Change in appetite

Hematologic/Lymphatic
____ Ease of bruising
____ Gums bleed easily
____ Enlarged glands

Check if you have had any of the following in the last 30 days:

☐Pain worse at night ☐Constant pain unrelated to motion ☐Unexplained weight loss
☐Loss of bowel or bladder control ☐Bacterial infection ☐Surgery ☐Fever or chills

Check if you have ever had any of the following:

☐History of Cancer ☐History of HIV ☐Use of Steroids ☐Use of IV Drugs ☐Blood Transfusions

NOTICE TO NEW PATIENTS: I understand that full payment is due at the end of each visit for services rendered. I give permission to the clinic to perform necessary tests and treatments.

AGREEMENT FOR PATIENTS WITH (AUTO/MED PAY) INSURANCE: I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this office does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on my indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any information you deem appropriate to any insurance company.

Signature _____ **Date** _____

#105A

Family Health History

Relation	First Name	Age	State of Health	If Deceased, Cause of Death	Age at Death
Father					
Mother					
Spouse					
Brothers and Sisters					
Children					
Other					

Patient _____ Date _____