

Patient Name: _____ Date of Birth: _____

Date: _____

Past Medical History:

- Y N Autoimmune Disorder
- Y N Blood Transfusion Date: _____
- Y N Colon Cancer
- Y N Depression
- Y N Diabetes Type 1
- Y N Diabetes Type 2
- Y N Blood Clots – DVT Date: _____
- Y N Hepatitis B

Check all Medical Conditions you have:

- Y N Hepatitis C
- Y N Hypertension
- Y N Thyroid Disease
- Y N Liver Disease
- Y N Osteoarthritis
- Y N Stroke – CVA
- Y N Seizure Disorder
- Other: _____

Past Surgical History:

<p>Surgery:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Date:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Family History:

	Age	Living or Deceased	Health Problems or Cause of Death
Mother			
Father			
Brother(s)			
Sister(s)			
Children			

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Where is the pain? Does it radiate or go anywhere else? _____

How did the pain start? _____

How long has the pain been present? _____

Is your pain: Constant Intermittent

On a scale of 0 to 10 (0 = no pain, 10 = worst pain), how severe is the pain on average? _____

What makes your pain better: _____

What makes your pain worse? _____

How would you describe the pain? (Please circle)

THROBBING SHOOTING STABBING ACHING RINGING SHARP TENDER

Associated Symptoms: (Please check all that apply)

- | | | | |
|---------------------------------------|---|-------------------------------------|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Room Spinning | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Issues with Swallowing | <input type="checkbox"/> Pressure | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Sensitive of Light | <input type="checkbox"/> Congestion | <input type="checkbox"/> Sinus Headaches |
| <input type="checkbox"/> Drainage | <input type="checkbox"/> Other: _____ | | |