

# CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records.

Today's Date  Signature of Patient \_\_\_\_\_  
Signature of Parent/Guardian \_\_\_\_\_

Patient Title: (check one)  Mr.  Mrs.  Ms.  Miss  Dr.  Prof.  Rev.

First Name \_\_\_\_\_ Nick Name \_\_\_\_\_

Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Suffix \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Home Email \_\_\_\_\_ Work Email \_\_\_\_\_

Which email address would you like us to use to communicate with you? (Check one)

Home  Work

Contact Method (Check one)

Primary Phone  Secondary Phone  Mobile Phone  Home Email  Work Email

Date of Birth  Age \_\_\_\_\_ Gender (Check one)  Male  Female  Unspecified

Marital Status (Check one)  Single  Married  Other SSN \_\_\_\_\_

Employment Status (Check one)

Employed  FT Student  PT Student  Other  Retired  Self Employed

Race (Check one)

- |                                   |   |                                      |  |
|-----------------------------------|---|--------------------------------------|--|
| <input type="checkbox"/> White    | <input type="checkbox"/> Black/African American | <input type="checkbox"/> Hispanic    | <input type="checkbox"/> American Indian/Alaskan Native          |
| <input type="checkbox"/> Asian    | <input type="checkbox"/> Asian Indian           | <input type="checkbox"/> Chinese     | <input type="checkbox"/> Filipino                                |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean                 | <input type="checkbox"/> Vietnamese  | <input type="checkbox"/> Native Hawaiian or other Pacific Island |
| <input type="checkbox"/> Samoan   | <input type="checkbox"/> Guamanian or Chamorro  | <input type="checkbox"/> Other _____ | <input type="checkbox"/> I choose not to specify                 |

Multi-Racial (Check one)  Yes  No  Unknown

Ethnicity (Check one)  Hispanic or Latino  Not Hispanic or Latino  I choose not to specify

Preferred Language (Check one)

- |                                  |                                     |   |  |  |                                 |
|----------------------------------|-------------------------------------|---|--|--|---------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish    | <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Chinese       | <input type="checkbox"/> French                  | <input type="checkbox"/> German |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Italian                | <input type="checkbox"/> Korean        | <input type="checkbox"/> Russian                 | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Arabic  | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Japanese               | <input type="checkbox"/> French Creole | <input type="checkbox"/> Greek                   | <input type="checkbox"/> Hindi  |
| <input type="checkbox"/> Persian | <input type="checkbox"/> Urdu       | <input type="checkbox"/> Gujarati               | <input type="checkbox"/> Armenian      | <input type="checkbox"/> I choose not to specify |                                 |

**Verification Question** (Choose only one question by checking the question, then give the answer to that question)

- What is the name of your favorite pet?       In what city were you born?       What high school did you attend?
- What is your favorite movie?       What is your mother's maiden name?       On what street did you grow up?
- What was the make of your first car?       When is your anniversary?       What is your favorite color?

**Verification Answer to the Chosen question:** \_\_\_\_\_

**Do you currently smoke tobacco of any kind?**     Yes     Former smoker     Never been a smoker

**If yes, how often do you smoke:**       Current every day smoker     Current sometimes smoker

**If yes, what is your level of interest in quitting smoking?**

- 0     1     2     3     4     5     6     7     8     9     10
- No interest* *Very Interested*

**Current medications, including dosage if known.**

**If there are no current medications, check here:**

- 1) \_\_\_\_\_ 5) \_\_\_\_\_
- 2) \_\_\_\_\_ 6) \_\_\_\_\_
- 3) \_\_\_\_\_ 7) \_\_\_\_\_
- 4) \_\_\_\_\_ 8) \_\_\_\_\_

**List any known allergies you have had to any medications.**

**If no allergies are known, check here:**

- 1) \_\_\_\_\_ 3) \_\_\_\_\_
- 2) \_\_\_\_\_ 4) \_\_\_\_\_

**Occupation** \_\_\_\_\_ **Employer** \_\_\_\_\_

**Who referred you to us?** \_\_\_\_\_ **How else did you hear about us?** \_\_\_\_\_

**What is your major complaint?** \_\_\_\_\_

**How long have you had this condition?** \_\_\_\_\_

**Have you had this or similar conditions in the past?** \_\_\_\_\_

**Do any positions make it feel worse?** \_\_\_\_\_

**Do any positions make it feel better?** \_\_\_\_\_

**Is this condition:**     Improved     Unchanged     Getting Worse

**Is this condition interfering with your:**     Work     Sleep     Daily Routine    **Other** \_\_\_\_\_

Other doctors or therapists who have treated **THIS** condition \_\_\_\_\_

What do you think caused this condition? \_\_\_\_\_

List surgical operations and years: \_\_\_\_\_

Do you have a family physician? Name: \_\_\_\_\_

Briefly list your main health problems: \_\_\_\_\_

Has any doctor diagnosed you with Hypertension presently?  Yes  No If yes, describe: \_\_\_\_\_

Has any doctor diagnosed you with Diabetes presently?  Yes  No If yes, what kind?  Type I  Type II

*If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?*  Yes  No  Not Sure

*If yes, other comments regarding Diabetes:* \_\_\_\_\_

Have you had an X-ray or CT scan or MRI of your **low back** spine in the past 28 days?  Yes  No

**To be performed by clinic staff:**

Height: \_\_\_\_\_ inches    Weight: \_\_\_\_\_ pounds    BP: \_\_\_\_\_ / \_\_\_\_\_

**REVIEW OF SYSTEMS** Check only the ones you now have or have had in the past.

<u>GENERAL</u>	NOW	PAST	<u>THROAT</u>	NOW	PAST	<u>GASTROINTESTINAL</u>	NOW	PAST
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>SKIN</u></b>			<b><u>NECK</u></b>			Irregular Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Masses	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>BREASTS</u></b>			Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>HEAD</u></b>			Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>GENITOURINARY</u></b>		
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Bumps	<input type="checkbox"/>	<input type="checkbox"/>	Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Last Eye Exam			Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>	Straining	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>LUNGS</u></b>			Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stones	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>EARS</u></b>			Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Small Stream	<input type="checkbox"/>	<input type="checkbox"/>
Ringings	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>HEART</u></b>			Urine Color		
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Spotting Between Periods	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>NOSE</u></b>			Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Contraception Type	_____	
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>	Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Age at First Period	_____	
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>BLOOD</u></b>			Duration of Cycle	_____	
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Flow	_____	
<b><u>MOUTH</u></b>			Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>	No. of Pregnancies	_____	
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	No. of Births	_____	
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	No. of Miscarriages	_____	
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>	No. of Abortions	_____	
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Flow	<input type="checkbox"/>	Heavy <input type="checkbox"/>
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Sugar in Blood	<input type="checkbox"/>	<input type="checkbox"/>	Mod	<input type="checkbox"/>	Light <input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Red Spots	<input type="checkbox"/>	<input type="checkbox"/>	Last Period	_____	
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>				Last Pap Smear	_____	
Blisters	<input type="checkbox"/>	<input type="checkbox"/>				Last Vaginal Exam	_____	
						Last Mammogram	_____	
						Last Prostate Exam	_____	

**NEUROLOGIC    NOW   PAST**

- Seizures
- Vertigo
- Dizziness
- Hand Trembling
- Loss of Sensation
- Incoordination
- Loss of Facial
- Weak Grip
- Paralysis
- Difficulty Speech
- Tingling
- Loss of Memory
- Numbness

**ENDOCRINE**

- Weight Loss
- Weight Gain
- Extremely Thin
- Heat Intolerance
- Cold Intolerance
- Hair Changes
- Breast Changes

**IMMUNIZATION/VACCINATION**

- DPT
- Mumps
- Smallpox
- Typhoid
- Tetanus
- Measles
- Pneumococcal
- Influenza
- Polio
- MMR

**BLOOD TYPE**

- A +       A -
- B +       B -
- AB +    AB -
- O +       O -
- Other \_\_\_\_\_

**BLOOD TRANSFUSIONS**

- Date \_\_\_\_\_
- Date \_\_\_\_\_
- Date \_\_\_\_\_
- Date \_\_\_\_\_

**PSYCHIATRIC    NOW   PAST**

- Hyperventilation
- Insecurity
- Depression
- Troubled Sleep
- Irritable
- Undecidedness
- Timid
- Hallucinations
- Loss of Memory
- Alcoholism
- Drug Addiction
- Drug Dependent
- Suicidal Thoughts
- Extreme Worry
- Sexual Problems

**MUSCULOSKELETAL    NOW   PAST**

- Muscle Pain
- Muscle Weakness
- Muscle Cramps
- Muscle Twitching
- Joint Stiffness
- Joint Pain

**PAST MEDICAL HISTORY. Check only the ones you have had in the past.**

- |  |  |
|--|--|
| Hay Fever <input type="checkbox"/>       | Parasites <input type="checkbox"/>         |
| Mumps <input type="checkbox"/>           | Epilepsy <input type="checkbox"/>          |
| Rheumatic Fever <input type="checkbox"/> | Paralysis <input type="checkbox"/>         |
| Allergies <input type="checkbox"/>       | Polio <input type="checkbox"/>             |
| Angina <input type="checkbox"/>          | Mental Illness <input type="checkbox"/>    |
| Cancer <input type="checkbox"/>          | Alcoholism <input type="checkbox"/>        |
| Tumor <input type="checkbox"/>           | Depression <input type="checkbox"/>        |
| Blood Disease <input type="checkbox"/>   | Nervous Breakdown <input type="checkbox"/> |
| Leukemia <input type="checkbox"/>        | Migraine <input type="checkbox"/>          |
| Heart Trouble <input type="checkbox"/>   | Gout <input type="checkbox"/>              |
| Varicose Veins <input type="checkbox"/>  | Hemorrhoids <input type="checkbox"/>       |
| Phlebitis <input type="checkbox"/>       | Prostate Problems <input type="checkbox"/> |
| Hypertension <input type="checkbox"/>    | Sexual Problems <input type="checkbox"/>   |
| Stroke <input type="checkbox"/>          | Gonorrhea <input type="checkbox"/>         |
| Ulcers <input type="checkbox"/>          | Syphilis <input type="checkbox"/>          |
| Jaundice <input type="checkbox"/>        | Diabetes <input type="checkbox"/>          |
| Skin Trouble <input type="checkbox"/>    | Bladder Trouble <input type="checkbox"/>   |
| Gallstones <input type="checkbox"/>      | Kidney Stones <input type="checkbox"/>     |
| Liver Trouble <input type="checkbox"/>   | Kidney Infections <input type="checkbox"/> |
| Hepatitis <input type="checkbox"/>       | Dysentery <input type="checkbox"/>         |

Date of Last Chest X-Ray \_\_\_\_\_  Normal    Abnormal

Last TB Skin Test \_\_\_\_\_  Normal    Abnormal

Allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY** List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____

**SOCIAL HISTORY** Check the boxes and fill in.

Current Weight \_\_\_\_\_ Have you recently lost or gained weight? \_\_\_\_\_

Mental Work     Heavy     Moderate     Light    Hours per day \_\_\_\_\_

Physical Work     Heavy     Moderate     Light    Hours per day \_\_\_\_\_

Exercise     Heavy     Moderate     Light    Hours per week \_\_\_\_\_ Type \_\_\_\_\_

Alcohol    Beer/Week \_\_\_\_\_    Liquor/Week \_\_\_\_\_    Wine/Week \_\_\_\_\_    No. of Years \_\_\_\_\_

Caffeine    Cups/Day \_\_\_\_\_    No. of Years \_\_\_\_\_  
 (Coffee, Tea, Cola)

Aspirin    No./Day \_\_\_\_\_    No. of Years \_\_\_\_\_    Others \_\_\_\_\_

**SYMPTOMS** Mark the areas of your symptoms on the figure to the right.

Use the following symbols:

Aches ^^^^    Numbness oooo    Pins/Needles ....    Stabbing ////

Mark an "X" on the following two lines:

How bad are your symptoms now?

\_\_\_\_\_ None \_\_\_\_\_ Most Severe

How bad have they been in the past?

\_\_\_\_\_ None \_\_\_\_\_ Most Severe

