CENTER FOR PREVENTIVE MEDICINE

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CURRENT AND PAST HISTORY (Please Print Clearly)

Patient Name:_____ Date of Birth:_____ Age:_____

Primary Care Physician:_____ Chief Complaint ☐ Right ☐ Left:_____

Date of Onset:_____ How did this injury occur: _____

Have you received prior treatment for this injury? Yes ☐ No ☐ If yes, list physician_____

Recently are your symptoms ☐ Worse ☐ Better ☐ Same Are you: ☐ Right Handed ☐ Left Handed

OCCUPATIONAL HISTORY

1. Are you currently working? ☐ Yes ☐ No What is your occupation?_____
2. What was your occupation at the time of the injury?_____ Same? ☐ Yes ☐ No
3. Date last worked:_____
4. If you are not working now, do you see yourself: (Check one or more)
   - ☐ Returning to the same job
   - ☐ Modifying your work
   - ☐ Changing jobs—different employer
   - ☐ Retraining or returning to school
   - ☐ Applying for early retirement or long term disability benefits

SOCIAL HISTORY

1. Do you smoke cigarettes? ☐ Yes ☐ No _____ packs per day x _____ years
2. If you do not smoke now, did you smoke in the past? ☐ Yes ☐ No _____ packs per day x _____ years
3. Do you drink alcoholic beverages ☐ Yes ☐ No If yes, how much per week?_____
4. Do you have a history of ☐ Alcoholism ☐ Drug Abuse ☐ Narcotic dependence/addiction ☐ None

PAST SURGICAL HISTORY

Surgery	Year	Surgery	Year

PAST MEDICAL HISTORY

Please check whether or not you have had the following problem

	YES	NO		YES	NO
Stomach Ulcers	☐	☐	Seizure Disorder	☐	☐
Cancer-If yes, what type?	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Hepatitis	☐	☐
Bronchitis/Emphysema	☐	☐	Thyroid disease	☐	☐
Asthma	☐	☐	Kidney stones	☐	☐
Heart Disease/Heart Attack	☐	☐	Kidney problems	☐	☐
Rheumatic disease arthritis	☐	☐	Prostatic problems	☐	☐
High Blood Pressure	☐	☐	Aneurysm	☐	☐
Stroke	☐	☐	Mental Illness	☐	☐

Please list any additional medical conditions:_____

MEDICATIONS AND ALLERGIES

Please list **current medications** (including non-prescriptions & herbal supplements

If you have had an allergic reaction to a medication please list below

Medication	Dose	Reason	Allergies	Side Effects
1.			1.	
2.			2.	
3.			3.	
4.			4.	
5.			5.	
6.			6.	
7.			7.	
8.			8.	

Are you allergic or have any allergies to the following?

X-ray/ IV Dye? ☐ Yes ☐ No **Latex?** ☐ Yes ☐ No **Iodone/Betadine prep?** ☐ Yes ☐ No

FAMILY HISTORY

Which family member has/had the following diseases listed below?

Cancer_____ Stroke_____ Diabetes_____

Heart Disease_____ Hypertension_____ Other_____

PAIN DRAWING

How bad is your pain now?

NO PAIN _____ WORST POSSIBLE PAIN

0 1 2 3 4 5 6 7 8 9 10

How bad is your pain at its worst?

NO PAIN _____ WORST POSSIBLE PAIN

0 1 2 3 4 5 6 7 8 9 10

How bad is your pain at its best?

NO PAIN _____ WORST POSSIBLE PAIN

0 1 2 3 4 5 6 7 8 9 10

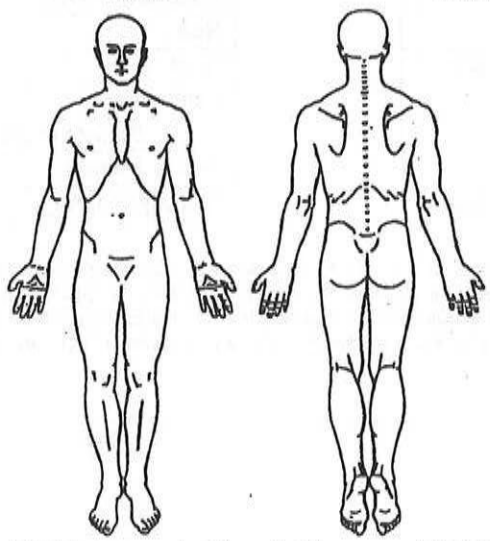
Pain at night that interferes with sleep? ☐ Yes ☐ No

Check which of the following activities change the nature of your pain, if applicable:

	Aggravates Pain	Relieves Pain	No Change
Sitting			
Standing			
Walking			
Rising from Sitting			
Bending Forward			
Bending Backward			
Lying on your back			
Lying on your stomach			
Driving			
Coughing/Sneezing			
Other:			

Instructions: Where is your pain now? Using the appropriate symbols below, mark the areas on your body where you fee the sensations described. Include all affected areas.

Aching ▲▲▲ Numbness ═══ Pins and Needles ooo Burning XXX Stabbing ///



Right Left Left Right

Front Back

Have you had the following (relating to your current injury)	Yes	No	If yes, what body part	Date
x-rays				
MRI				
CT Scan				
Bone Scan				
EMG (Nerve/muscle test)				

Have you had the following (related to your current pain)			Did the treatment decrease your pain	
	Yes	No	Yes	No
Injections				
Physical Therapy/Occupational Therapy				
Medications				
Chiropractor				
Osteopathic Manipulation				

REVIEW OF SYSTEMS

Constitutional	Yes	No
Weight loss		
Fatigue		
Headaches		
Chills/Night Sweats		
Cardiovascular	**Yes**	**No**
Chest pain or angina		
Palpitations		
Swelling of feet/hands		
Irregular heart beat		
Respiratory	**Yes**	**No**
Shortness of breath		
Asthma or wheezing		
Hematologic/Lymphatic	**Yes**	**No**
Bleeding/bruising easily		
Blood clots		
Endocrine	**Yes**	**No**
Heat or cold intolerance		
Skin	**Yes**	**No**
Rash		
Infection		
Ear/Nose/Throat	**Yes**	**No**
Trouble swallowing		
Dizziness		
Lightheadedness		
Eyes	**Yes**	**No**
Double vision		
Musculoskeletal	**Yes**	**No**
Joint Pain		
Joint Stiffness		
Muscle Weakness		
Difficulty in walking		
Joint swelling		
Cramps		
Neurological	**Yes**	**No**
Convulsions/Seizures		
Numbness or tingling		
Head Injury		
Loss of bowel/bladder control		
Psychiatric	**Yes**	**No**
Memory Loss		
Depression		
Trouble sleeping		
Anxiety		
Confusion		
GastroIntestinal	**Yes**	**No**
Reflux		
Diarrhea		
Constipation		
Genitourinary	**Yes**	**No**
Painful urination		
Difficulty urinating		

I acknowledge that a copy of the privacy notice was made available to me in this office. The notice is in a clear and prominent location where I can read it if I choose, or I can ask for a copy to take with me. I also acknowledge the notice is available even if treated during an emergency situation.. I understand that in the hospital, physicians and other health care providers included in the organization are participating solely for the limited purpose of coordinating the protection of my privacy rights in accordance with the HIPAA Act of 1996, and that all members of the medical staff associated with the hospital are not agents or employees of the hospital by virtue of their participation in this agreement.

Patient/Patient's Representative Signature Date

Physician Signature Date