PATIENT HISTORY

Patient Name:_____**DOB**:_____**MRN#**_____
Chief Compaint:_____**Onset Date**:_____
Location:_____ **Severity:** (Circle One) Mild Moderate Severe
How Long Does it Last? _____ **Type of Pain**: _____
(minutes/hours) (burning, numbness, sharp, achy, etc)
Modifying Factors (worsened or improved with a specific position or activity? _____
_____
Are there any other **associated symptoms**?:_____

Flu Shot: Yes or No **Date** : _____

REVIEW OF SYSTEMS: **Please circle all that apply**

Weight Loss or Gain	Chest Pain	Cough	
Excessive Fatigue	Heart Palpitations	Sputum Production	Hallucinations
Fever Chills or Night Sweats	Swelling	Shortness of Breath	Anxiety or Depression
Excessive Daytime Sleepiness	Blurry Vision	Joint Pain	Frequent Urination
Snoring at Night	Double Vision	Joint Swelling	Night time Urination
Episodes of Stopping Breathing	Loss of Vision	Lower Back Pain	Difficulty with Urination
While sleeping	Dry Eyes or Mouth	Neck Pain	Sexual Dysfunction
Difficulty Falling Asleep	Hearing Loss	Arm Pain	
Restless Sleep	Ringing In the Ears	Leg Pain	Abnormal Bleeding or Bruising
Insomnia			
Headaches	Difficulty with Balance	Stomach Pains	Hair Loss
Difficulty with Speech	Dizziness	Constipation	Abnormal Menses
Difficulty Swallowing	Room Spinning / Vertigo	Diarrhea	Excessive Thirst
Numbness in Hand	Frequent Falls	Nausea	Excessive Hot or Cold
Numbness in Feet	Memory Difficulty	Vomiting	
Weakness in the Arms	Loss of Consciousness		Abnormal Smells
Weakness in the Legs	Episodes of Confusion	Rash or Itching	Tremors or Shaking

PAST MEDICAL HISTORY: Please circle all that supply

Diabetes	High Cholesterol	Seizures	Stroke	Back Pain	Anemia
Neck Pain	Psychiatric	Hypertension	Cancer	Heart Disease	Other_____

Do You have (circle all that apply): Pacemaker / Defibrillator Artificial Heart Valve (Type): _____ Stent
Other implanted devices: _____
CURRENT MEDICATIONS (include non-prescription, over the counter medications, vitamins, and herbs):_____
_____
_____
Past Surgical History:_____
Past Hospitalizations:_____
ALLERGIES TO MEDICATIONS, FOOD, DYES, OR NONE:_____
Family History (Please indicate relation in the space provided):

Hypertension:_____	Parkinson's Disease:_____	Migraines:_____
Multiple Sclerosis:_____	Dementia Disease: _____	Neuropathy: _____
Muscle Weakness: _____	Stroke: _____	Cancer:_____
Diabetes: _____	Other:_____	

Social History: (Please Circle) Single Married Significant Other Divorced Widowed
Employment :_____ **Level of Education**: _____
Use of (please circle all that supply): Tobacco Alcohol Drugs

Do you have HIV?	Yes	or	No	Do you have risk factors for HIV?	Yes	or	No
Do you have Lyme Disease?	Yes	or	No	Do you have risk factors for Lyme Disease?	Yes	or	No

_____ _____
Patient Signature Date **Physician Signature** Date