PATIENT HISTORY

Patient Name:__________________ **DOB:**__________________ **MRN#**__________________
Chief Complaint:__________________ **Onset Date:**__________
If Pain- Location:__________________ **severity of pain:** (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** : ______
Covid Vaccine: Yes or No **Date** : ______

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

Weight Loss	Chest Pain	Cough	
Weight Gain	Heart Palpitations	Sputum Production	Hallucinations
Excessive Fatigue	Swelling	Shortness of Breath	Anxiety
Fever			Depression
Excessive Daytime Sleepiness	Blurry Vision	Joint Pain	Frequent Urination
Snoring at Night	Double Vision	Joint Swelling	Difficulty with Urination
Episodes of Stopping Breathing While sleeping	Loss of Vision	Lower Back Pain	Sexual Dysfunction
	Dry Eyes or Mouth	Neck Pain	
	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	
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	Lyme Disease
HIV	**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:(type)__________
Diabetes: __________	**Other:**__________	

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

__________________ __________________

Patient Signature Date **Physician Signature** Date