Confidential Patient Case History

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

Name_____ Birthday_____ Sex ☐ M ☐ F

What is your major complaint?_____

How long have you had this condition_____ Have you had similar conditions in the past_____

Is this condition interfering with your: □ Work □ Sleep □ Daily routine Other_____

Previous treatment for that condition_____

Previous tests or imagery_____

Do you have a family physician?_____Name_____

Allergies:_____

Medication, dosage and frequency:_____

List of surgical operations and years:_____

_____

Have you been in an auto accident or any other personal injuries ☐ Yes ☐ No Describe_____

_____

Caffeine use?_____ Tobacco?_____ Drug?_____ Alcohol?_____

Past medical history

Anemia	_____	years:_____	Heart attack	_____	years:_____
Angina	_____	years:_____	High blood pressure	_____	years:_____
Arthritis	_____	years:_____	Kidney disease	_____	years:_____
Asthma	_____	years:_____	Liver disease	_____	years:_____
Bladder infection	_____	years:_____	Stomach ulcer	_____	years:_____
Bleeding disorder	_____	years:_____	Stroke	_____	years:_____
Cancer	_____	years:_____	Thryroid disorder	_____	years:_____
Depression	_____	years:_____	Tuberculosis	_____	years:_____
Epilepsy	_____	years:_____	Other_____	_____	years:_____
Gout	_____	years:_____			

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

General	Now	Past
Weakness	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Night sweats	☐	☐
Fainting	☐	☐
Weight loss	☐	☐

Skin	Now	Past
Color changes	☐	☐
Hair changes	☐	☐
Moles	☐	☐
Rashes	☐	☐
Sores	☐	☐
Masses	☐	☐

Head + Eyes	Now	Past
Headaches	☐	☐
Injuries	☐	☐
Bumps	☐	☐
Glasses	☐	☐
Contacts	☐	☐
Cataracts	☐	☐

Ears	Now	Past
Hard of hearing	☐	☐
Deafness	☐	☐
Ringing	☐	☐
Discharge	☐	☐
Earache	☐	☐
Dizziness	☐	☐
Room spins	☐	☐

Nose	Now	Past
Decreased smell	☐	☐
Bleeding	☐	☐
Pain	☐	☐
Discharge	☐	☐
Obstruction	☐	☐
Post nasal drip	☐	☐
Deniated septrum	☐	☐
Sinus congestion	☐	☐

Mouth	Now	Past
Bleeding gums	☐	☐
Sores	☐	☐
Dental problems	☐	☐
Bad breath	☐	☐
Loss of taste	☐	☐
Dry mouth	☐	☐
Ulcers	☐	☐
	☐	☐

Throat	Now	Past
Soreness	☐	☐
Bad tonsils	☐	☐
Hoarseness	☐	☐
Pain	☐	☐
Trouble swallowing	☐	☐
Reccurent infections	☐	☐

Neck	Now	Past
Neck enlargment	☐	☐
Stiff neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐

Breasts	Now	Past
Discharge	☐	☐
Lumps	☐	☐
Pain	☐	☐
Bleeding	☐	☐
Nipple changes	☐	☐
Skin changes	☐	☐

Lungs	Now	Past
Cough	☐	☐
Phlegm	☐	☐
Blood	☐	☐
Short of breath	☐	☐
Wheezing	☐	☐
Pain	☐	☐
Congestion	☐	☐

Heart	Now	Past
Murmur	☐	☐
Palpitations	☐	☐
Arithmia	☐	☐
Swollen Extemities	☐	☐
Cold exremities	☐	☐
Chest pain/ Pressure	☐	☐
Varicose veins	☐	☐
Blood clots	☐	☐
Blue extremities	☐	☐

Blood	Now	Past
Low blood iron	☐	☐
Easy bruising	☐	☐
Easy bleeding	☐	☐
Swollen nodes	☐	☐
Painful nodes	☐	☐
Red spots	☐	☐

Gastrointestinal	Now	Past
Nausea	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Abnominal Pain	☐	☐
Irregular bowel habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Hemorrhoids	☐	☐
Poor appetite	☐	☐
Food intolerance	☐	☐
Bloody stools	☐	☐
Black stools	☐	☐

Genitourinary	Now	Past
Urgency	☐	☐
Incontinence	☐	☐
Straining	☐	☐
Frequent Voiding	☐	☐
Stones	☐	☐
Burning	☐	☐
Bed wetting	☐	☐
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Small stream	☐	☐
Cloudy urine	☐	☐
Spotting between	☐	☐
Periods	☐	☐
Menstrual cramps	☐	☐
Discharge	☐	☐
Itching	☐	☐
Painful intercourse	☐	☐
Irregular periods	☐	☐
Hot flashes	☐	☐
Contraception type		
No. of pregnacies		
No. of births		
Menstrual flow □Heavy□Mod□Light		
Last period		
Last pap smear		
Last vaginal exam		
Last mammogram		
Last prostate exam		

MSK/Neuro	Now	Past
Joint pain	☐	☐
Muscle weakness	☐	☐
Numbness	☐	☐
Poor balance	☐	☐

Name_____

Signature_____

Date