

Confidential Patient Health Record

Date: ___/___/___

Personal History

Circle One: Divorced Married Single Separated Widowed Birth Date: ___/___/___ Age: ___
 First: ___ Middle: ___ Last: ___ Gender: Male / Female
 Address: ___ Apt # ___
 City: ___ State: ___ Zip: ___ County: ___ Country: ___
 Home Phone: (___) ___-___ Cell Phone: (___) ___-___
 Social Security #: ___-___-___ Fax #: (___) ___-___
 Driver's License #: ___ State: ___ Email Address: ___
 Spouses Name: ___
 Ages of Children: ___

Employer

Business Name: ___ Occupation/Job Title: ___
 Business Address: ___
 Business Phone: (___) ___-___ Type of Work: ___

How did you hear about us? _____

Emergency Contact

Name: ___ Phone Number: (___) ___-___
 Address: _____
 Relationship: _____

Who Is Responsible For Your Bill?

Self Worker's Comp Auto Insurance Medicare Medicaid Other (be specific): _____
 Personal Health Insurance Carrier: _____ Health ID Card #: _____
 Insured Person's Name: _____ Group #: _____
 Insured Person's Date of Birth: _____ Primary Care Physician: _____
 Insured Person's Social Security #: ___-___-___ Pharmacy: _____

CURRENT HEALTH CONDITION

Chief complaint (Why you are here today): _____

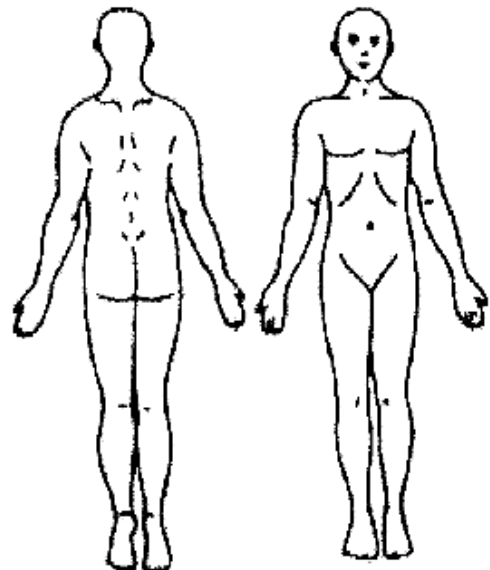
Use the letters below to indicate the type and location of you sensations right now:
 A=Ache B=Burning N=Numbness
 P=Pins & Needles S=Stabbing O=Other

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →
 When did this condition begin? ___/___/___
 Has it ever occurred before? Yes No
 When? _____
 Is the condition: Auto Related Work Related
 No Injury Other

Explain: _____

 Date of Accident: _____
 Time of Accident: _____
 Complaint/Pain Onset Date: _____
 If Work Related:
 Have you filed an injury report with your employer? Yes No
 Claim #: _____



Have you seen other doctors for this condition? Yes No If yes, Who? (Name) _____

Location of Office: _____ Type of Treatment: _____

Were you satisfied with the results of your treatment? Yes No Explain: _____

Are you currently taking any prescription medications? Yes No. If yes, please mark or list below (be specific).

Allergy Medication Anti-Depressants Blood Pressure Medication Insulin Muscle Relaxers
 Nerve Pills Pain Killers Other (please be specific): _____

Do you wear any of the following? Yes No. If yes, please mark: Heel Lifts Innersoles Arch Supports Orthotics

Please list any other conditions you feel we should know about – even if unrelated: _____

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

REVIEW OF SYSTEMS – Please fill out all of the sections, even if “DENY”.

Constitutional: I... Deny Any Constitutional Issue (s)

Chills Daytime Somnolence (Drowsiness) Fatigue Fever Night Sweats
 Weight Gain Weight Loss

Eyes/Vision: I... Deny Any Eyes/Vision Issue (s)

Blindness Blurred Vision Cataracts Change in vision Double Vision
 Eye Pain Field Cuts (visual field defect) Glaucoma Itching (around the eyes) Photophobia
 Tearing Wears Glasses and/or Contact lenses

Ears, Nose and Throat: I... Deny Any Ears, Nose and Throat Issue (s)

Bleeding Dental Implants Dentures Difficulty Swallowing Discharge
 Dizziness Ear Drainage Ear Infection(s) Ear Pain Fainting
 Headaches Head Injury (history of) Hearing Loss Hoarseness Loss of Smell
 Nasal Congestion Nose bleeds (frequent) Post Nasal Drip Rhinorrhea (Runny nose) Sinus Infections
 Snoring Sore Throats (frequent) Tinnitus (Ringing in Ears) TMJ problems

Respiration: I... Deny Any Respiratory Issue (s)

Asthma Cough Coughing up blood Shortness of Breath Sputum Production Wheezing

Cardiovascular: I... Deny Any Cardiovascular Issue (s)

Angina (chest pain or discomfort) Chest Pain Claudication (leg pain or achiness) Heart Murmur
 Heart Problems Orthopnea (difficulty breathing while lying down) Palpitations (irregular or forceful beating of the heart)
 Paroxysmal Nocturnal Dyspnea (waking at night with shortness of breath) Shortness of Breath with Exertion or Exercise
 Swelling of Legs Ulcers Varicose Veins

Gastrointestinal: I... Deny Any Gastrointestinal Issue (s)

Abdominal Pain Belching Black, Tarry Stools Constipation Diarrhea
 Difficulty Swallowing Heartburn Hemorrhoids Indigestion Jaundice (yellowing of the skin)
 Nausea Rectal Bleeding Abnormal Stool Caliber (quality) Abnormal Stool Color
 Abnormal Stool Consistency Vomiting Vomiting Blood

Female: I... Deny Any Female Issue (s)

Birth Control Therapy Breast Lumps/Pain Burning Urination Cramps Frequent Urination
 Hormone Therapy Irregular Menstruation Urine Retention Vaginal Bleeding Vaginal Discharge

Male: I... Deny Any Male Issue (s)

Burning Urination Erectile Dysfunction Frequent Urination Hesitancy/Dribbling Prostate Problems
 Urine Retention

Endocrine: I... Deny Any Endocrine Issue (s)

- Cold Intolerance Diabetes Excessive Appetite Excessive Hunger Excessive Thirst
 Frequent Urination Goiter Hair Loss Heat Intolerance Unusual Hair Growth
 Voice Changes

Skin: I... Deny Any Skin Issue (s)

- Changes in Nail Texture Changes in Skin Color Hair Growth Hair Loss Hives Itching
 Paresthesia (numbness, prickling, or tingling) Rash History of Skin Disorders Skin Lesions/Ulcers Varicosities

Nervous System: I... Deny Any Nervous System Issue (s)

- Dizziness Facial Weakness Headaches Limb Weakness Loss of Consciousness
 Loss of Memory Numbness Seizures Sleep Disturbance Slurred Speech
 Stress Strokes Tremors Unsteadiness of Gait

Psychologic: I... Deny Any Psychologic Issue (s)

- Anhedonia (inability to experience joy or enjoy life) Anxiety Appetite Changes Behavioral Change(s)
 Bipolar Disorder Confusion Convulsions Depression Insomnia Memory Loss
 Mood Change(s)

Allergy: I... Deny Any Allergy Issue (s)

- Anaphylaxis (history of) Food Intolerance Itching Nasal Congestion Sneezing

Hematology: I... Deny Any Hematologic Issue (s)

- Anemia Bleeding Blood Clotting Blood Transfusion(s) Bruises easily Fatigue Lymph Node Swelling

PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.

Childhood Illness: I... Deny Any Childhood Illness (es)

- ADD Allergies/Hayfever Asthma Atopic Dermatitis (Eczema) Bedwetting
 Cerebral Palsy Chicken Pox Depression Diabetes Ear Infections
 Fetal Drug Exposure Food Allergies Headaches Hepatitis HIV
 Measles Mumps Rash Scoliosis Seizure Disorder
 Sickle Cell Anemia Spina Bifida Other (please describe): _____

Adult Illness: I... Deny Any Adult Illness (es)

- Alzheimers Anemia Arthritis Asthma Cancer
 Chicken Pox Crohn's/Colitis CRPS (RSD) CVA (stroke) Cystic Kidney Disease
 Depression Diabetes (Insulin) Diabetes (Non insulin) Ear Infections (frequent) Emphysema
 Eye Problems Fibromyalgia Heart Disease Hepatitis HIV
 Hypertension Influenzal Pneumonia Liver Disease Lung Disease Lupus Erythema (discoid)
 Lupus Erythema (systemic) Multiple Sclerosis Parkinson's Disease Pleurisy Pneumonia
 Psychiatric Problems Scoliosis Seizure Disorder Shingles STD's (unspecified)
 Suicide Attempt(s) Thyroid Problems Vertigo
 Past history of similar symptoms to your current condition Other Illness (please be specific): _____

Surgeries: I... Deny Any Surgery (ies)

- Angioplasty Appendectomy Caesarian Section Cardiac Catheterization Carpal Tunnel Repair
 Coronary Artery Bypass Cosmetic D & C Dental Surgery Gallbladder
 Hemorrhoidectomy Hernia Repair Hysterectomy Joint Reconstruction Joint Replacement
 Laminectomy Mastectomy Pacemaker Insertion Rotator Cuff Spinal Fusion
 Tonsilectomy Other (please be specific): _____

Ob/Gyn: I... Deny Any Ob/Gyn Issue (s)

- I... have never been pregnant have been pregnant in the past am currently pregnant
_____ Number of pregnancies _____ Number of complicated pregnancies _____ Number of uncomplicated pregnancies
_____ Number of miscarriages _____ Number of terminated pregnancies _____ Number of Epidural Injections
_____ Number of C-Sections _____ Number of vaginal deliveries

Menstrual History: Age of Onset _____

- My menses is Regular Irregular; I am currently in Metaphase Menopause; Date of Last Menses ____/____/____

