Confidential Patient Health Record

Date:____/_____/_____

Personal History

First:_____ **Middle**:____ **Last:** _____ **Gender: Male / Female**
Address: _____Apt # _____
City: _____ **State:** _____ **Zip:** _____ **County:** _____ **Country:** _____
Home Phone: (_____)_____-_____ **Cell Phone:** (_____)_____-_____
Social Security #: _____-_____-_____ **Birth Date:** ____/_____/_____ **Age:**_____
Email Address: _____ **Sign up for our Email Newsletter? YES NO**

Employer

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

Circle One: Divorced Married Single Separated Widowed
Spouses Name: _____ **Spouses Employer:**_____
Spouses Occupation: _____ **Work Phone# :** _____
Ages of Children: _____

How were you referred to our office? _____

Emergency Contact

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

Who Is Responsible For Your Bill?
Self Health Insurance Work. Comp Auto Ins. Medicare Other (be specific):_____
Insurance Carrier: _____ **ID #:** _____
Insured Person's Name: _____ **Group #:** _____
Insured Person's Date of Birth: _____ **Primary Care Physician:** _____
Insured Person's Social Security #: _____-_____-_____

CURRENT HEALTH CONDITION

Chief complaint (Why you are here today):_____
_____
_____

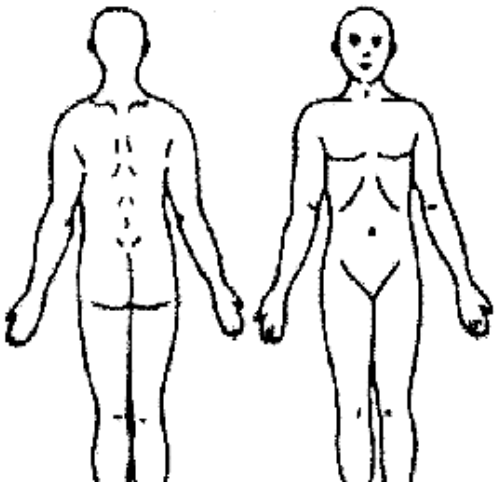
Use the letters below to indicate the type and location of you sensations right now:
A= Ache B=Burning N=Numbness
P=Pins & Needles S=Stabbing O=Other

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

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

Does your pain radiate? Yes No
If yes, describe: _____
Have you lost time from work? _____



Continued:

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:

_____
_____

Daily Activities: Effects of Current Condition on Performance

Care –Infirm Family:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Carrying Groceries:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Change Posn–Sit-Stand:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Climb Stairs:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Daily Pet Care:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Driving:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Ext Computer Use:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Household Chores:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Lift Children:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Self Care–Bathing:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Self Care–Dressing:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Self Care–Shaving:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Sexual Activities:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Sleep:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Static Sitting:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Static Standing:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Walking:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Yard Work:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (limited)	**Sev** Unable to Perform
_____	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (limited)	**Sev** Unable to Perform
_____	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (limited)	**Sev** Unable to Perform
_____	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (limited)	**Sev** Unable to Perform

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) (Pertaining to the Body as a Whole)

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

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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)
Alzheimer's 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
E ye 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
Tonsillectomy 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 _____/_____/_____

Injuries: I… Deny Any Injury (ies)
Back Injury Broken Bones Severe Fall Fracture Disability
Head Injury Industrial Accident Joint Injury Severe Laceration Motor Vehicle Accident
Mild/Moderate Soft Tissue Injury Severe Soft Tissue Injury

Immunizations: I… Deny Any Immunization (s)
DTaP(diphtheria, tetanus, and pertussis) Flu Hepatitis A Hepatitis B Hepatitis C
Influenza IPV (Polio) MMR (measles, mumps, and rubella) Pneumococcal
PPD (Mantoux Test-TB) Small Pox TB Varivax (chicken pox) Whooping Cough (Pertussis)

Non-Drug Allergies: **I… Deny Any Non-Drug Allergy (ies)**

Animals Dairy Eggs Food Coloring Mold Pollen Wheat

Other (please be specific): _____

Family History

Condition (please be specific)

General Family	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had: _____
Father	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had: _____
Mother	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had: _____
Paternal Grandfather	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had: _____
Paternal Grandmother	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had: _____
Maternal Grandfather	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had: _____
Maternal Grandmother	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had: _____
Son (s)	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had: _____
Daughter (s)	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had: _____
Brother (s)	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had: _____
Sister (s)	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had: _____

Social History

Alcohol: Never Social Consumption only Beer Liquor Wine ; _____ oz ____ glasses; Day Week Month

Diet (please mark all that apply): High Fat High Fiber High Protein High Salt Low Calorie Low Carb Low Fiber Low Salt Low Sugar

Education (please mark the highest level completed): Preschool Elementary Middle Junior High Votech In High School Did Not Finish High School High School Diploma Post High School Classes Assoc/Technical Degree In College College Degree In Graduate School Graduate Degree Doctorate Other: _____

Drugs: Deny any illegal drug use Deny use of IV drugs Have not used drugs since _____ Have used drugs for _____

Tobacco: Deny Tobacco Use Do not smoke cigars, cigarettes or pipe Live with a smoker Quit smoking

Smoke; # _____ per Day Week Month Chew; #_____cans per Day Week Year