

II. PAST HISTORY

1. Please list any past hospitalizations and past surgeries and include the year of each:

2. Please circle any of the following that you have had in the past: meningitis, encephalitis, polio, fainting, convulsions, epilepsy, head injury, unconsciousness, diabetes, tuberculosis, lung disease, high blood pressure, heart disease, stomach disease, liver disease, kidney disease, neck trouble, back trouble, a stroke, cancer, or venereal disease.

III. FAMILY HISTORY

	AGE (OR AGE AT DEATH)	CAUSE OF DEATH	HEALTH	MAJOR DISEASE(S)
FATHER				
MOTHER				
BROTHERS				
SISTERS				
CHILDREN				

1. Are there any diseases that run in your family? If so, please list:

IV. SOCIAL HISTORY

1. Please circle any of the following that apply to you: married, divorced, single, widow, employed, unemployed, retired, disabled.

2. Where were you born?

3. List the type of work you have done in the past and present, and approximately the number of years in this work.

4. List your activities of interest.

5. Please fill in the following: HEIGHT _____ WEIGHT _____

6. WOMEN: NUMBER OF PREGNANCIES _____ LIVE BIRTHS _____

V. REVIEW OF SYSTEMS (Please circle appropriate answer.)

Do you have problems with:

Headaches	YES	NO
Smell or tastes	YES	NO
Eyes or vision, wear glasses	YES	NO
Ears or hearing	YES	NO
Swallowing	YES	NO
Speech or talking	YES	NO
Breathing	YES	NO
Asthma	YES	NO
Chest Pain	YES	NO
Abnormal heartbeats	YES	NO
Stomach trouble	YES	NO
Bladder trouble	YES	NO
Controlling urination	YES	NO
Bowel Trouble	YES	NO
Controlling bowel movements	YES	NO
Skin trouble	YES	NO
Bleeding trouble or easy bruising	YES	NO
Weight	YES	NO
Appetite	YES	NO
Sleep	YES	NO
Weakness of arms or legs	YES	NO
Numbness of arms or legs	YES	NO
Dizziness	YES	NO
Balance	YES	NO

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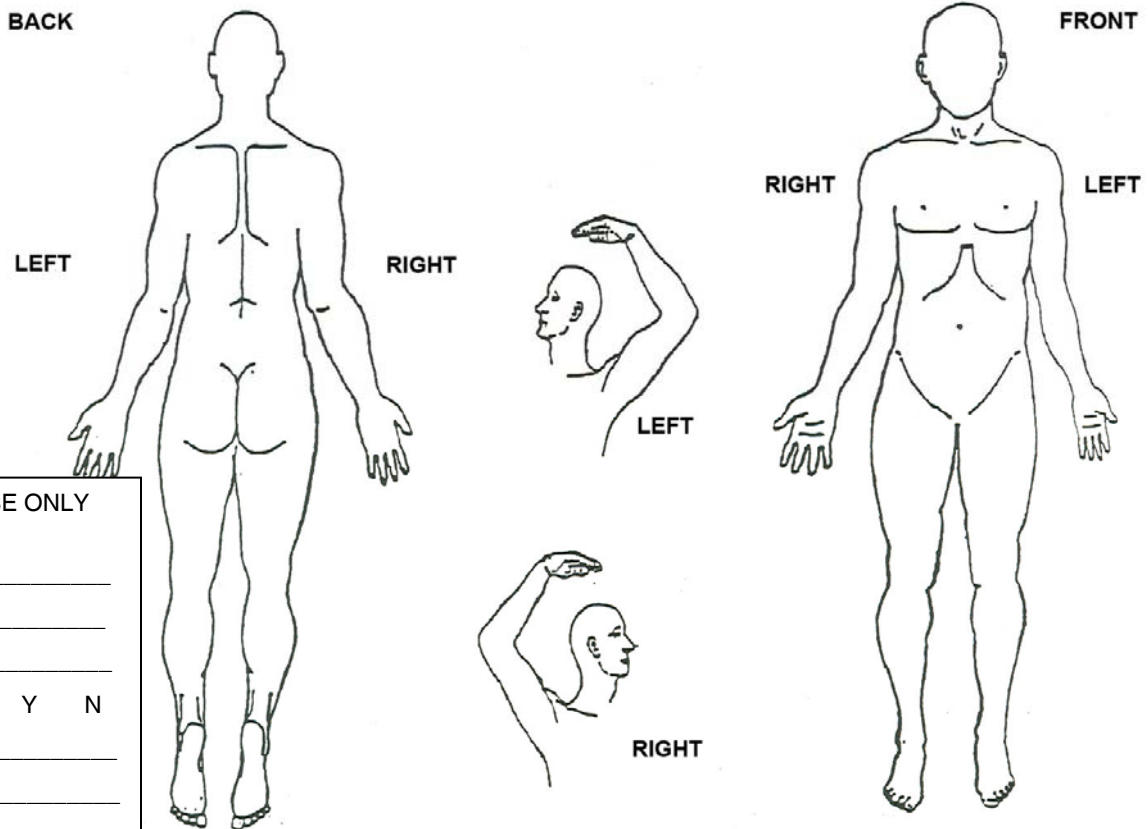
Patient Name: _____		Date: _____
Private Insurance: Yes No	Workers Comp: Yes No	
Current Medications: _____		

How bad is your pain now? Please place a mark on the line showing where your pain level is:

No Pain (0) ----- (5) ----- (10) Worst Possible

Where is your pain now? Mark the areas on your body (diagram below) where you feel the described sensations. Use the appropriate symbol. Mark the areas where your pain radiates. Include all affected areas. Just to complete the picture, please draw in your face.

Aching: ^^^^^ **Numbness:** 000000 **Pins & Needles:** **Burning:** xxxxxx **Stabbing:** \\\



OFFICE USE ONLY	
WT:	_____
HT:	_____
B/P:	_____
B/P MEDS:	Y N
LENGTH:	_____
TEMP:	_____
P:	_____
R:	_____
LMP:	_____

Dictation done Job# _____