# PATIENT HISTORY

Patient Name:_____ Today's Date:_____
Age:_____ Date of Birth:_____ Sex:_____ Primary Care Physician (or referring doctor): _____
Marital Status: ( )Single, ( )Married_____yrs, ( )Divorced_____yrs, ( )Widowed _____yrs
Occupation:_____ Employer:_____
( ) Currently Employed ( )Retired - If retired, date of last employment:_____
Highest Level of Education:_____ Hobbies:_____

**Reason For Your Visit Today**:_____ _____
_____
_____

**Prior loss of consciousness, passing out or Trauma:** (include year and type of injuries): _____
_____
_____
_____

**Surgery:** (include head/brain, neck or another major surgery's give year/location/surgeon if you remember)
_____
_____
_____

**Medications:** (list all current and recent prescribed/over the counter medications. If you have a list we will copy if for you.)
_____
_____

**Allergies:**_____
_____

**Medical History** (Any major illness, hospitalization, current diagnoses see below): _____
_____
_____
_____
_____

Last Flu Vaccine _____
Last Pneumonia Vaccine _____
Colonoscopy screening Yes or No if yes Date_____

**Social History**:
Smoke? ( )No ( )Yes, ____ packs per day.
Drink? ( )No ( )Yes,____ drinks per day.
Caffeine? ( )No ( )Yes,____ drinks per day.
Illicit substance ( )No ( )Yes

**Family Medical History:** List any family history of stroke, seizure, nerve, muscle, memory, tremors, Parkinson's d/s, & migraines. Your Mother, Father and Grandparents current illnesses or cause and year/age of their death**:**

_____
_____
_____

Are you seasonal**: Yes or No**

**Review of Symptoms:** Check any items below that may apply.

| **General/Endo/Derm/Psych** | | **Brain** | **Lung/Cardio/ Vascular** | **GI / Liver / URO** | **Muscular/ Skeletal** |
|---|---|---|---|---|---|
| ( ) Weight Loss | ( ) Weakness | ( ) Headache | ( ) Chest Pain | ( ) Nausea or Vomiting | ( ) Osteoporosis |
| ( ) Weight Gain | ( ) Numbness | ( ) Stroke | ( ) Palpitations | ( ) Diarrhea | ( ) Back Pain |
| ( ) Cold/Heat Intolerance | ( ) Imbalance | ( ) TIA | ( ) High Blood Pressure | ( ) Constipation | ( ) Neck Pain |
| ( ) Rash/Hives | ( ) Visual Change | ( ) Seizures | ( ) Heart Attack/Chest pain | ( ) Blood In Urine / Stool | ( ) Hip Pain |

| | | | | | |
|---|---|---|---|---|---|
| ( ) Bleed Easily | ( ) Depression | ( ) Alzheimer's | ( ) Snoring / Sleep Apnea | ( ) Incontinence | ( ) Joint Pain / Swelling |
| ( ) Bruise Easily | ( ) Anxiety | ( ) Memory Difficulty | ( ) Difficulty Sleeping | ( ) Urinary Changes | ( ) Other: _____ |
| ( ) Fever | ( ) Drug Abuse | ( ) Nervous Breakdown | ( ) Cough | ( ) Ulcer(s) | ( ) Other: _____ |
| ( ) Fatigue | ( ) Loss of Energy | ( ) Other: _____ | ( ) Asthma | ( ) Other: _____ | ( ) Other: _____ |
| ( ) Suicide Attempt | ( ) Other:_____ | ( ) Other: _____ | ( ) Other: _____ | ( ) Other: _____ | ( ) Other: _____ |
| ( ) Blood Transfusion | | | | | |

**All other Systems are negative _____**

**Patient / Responsible Party Signature:_____ Date:_____**

Patient's Name (Printed):_____