PATIENT HISTORY
PERSONAL HISTORY

Patient____ Date________________________
Childhood Diseases: Measles__________ Mumps_________ Chicken Pox_________ Others___________
Unusual Childhood Diseases:____
Adult Illnesses or Conditions: ____
Surgeries/Hospitalizations:____
Fractures:____
Medications:____
Are you allergic to any drugs or medications?____
Last Physical (date) ___________________________________ Findings:_____________________

Chief Symptoms

____
____
____
____

Have you ever had the same or similar condition? Yes______ No______ If yes, when and describe ______
____
Have you seen any other doctors for this condition?____
Is the condition due to injury or sickness arising out of employment? ___________________________________
Is the condition due to injury or sickness arising out of an auto or other accident? _________________________
Days lost from work?____________ Date symptoms appeared or accident happened __________________________

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter N if you have these conditions now or P if you have had these conditions previously.

N = Now P = Previously

Symptom		Symptom	
Headaches_________ Frequency	________	Loss of Balance	__________
Neck Pain	________	Fainting	__________
Stiff Neck	________	Loss of Smell	__________
Sleeping Problems	________	Loss of Taste	__________
Back Pain	________	Unusual Bowel Patterns	__________
Nervousness	________	Feet Cold	__________
Tension	________	Hands Cold	__________
Irritability	________	Arthritis	__________
Chest Pains/Tightness	________	Muscle Spasms	__________
Dizziness	________	Frequent Colds	__________
Shoulder/Neck/Arm Pain	________	Fever	__________
Numbness in Fingers	________	Sinus Problems	__________
Numbness in Toes	________	Diabetes	__________
High Blood Pressure	________	Indigestion Problems	__________
Difficulty Urinating	________	Joint Pain/Swelling	__________
Weakness in Extremities	________	Menstrual Difficulties	__________
Breathing Problems	________	Weight Loss/Gain	__________
Fatigue	________	Depression	__________
Lights Bother Eyes	________	Loss of Memory	__________
Ears Ring	________	Buzzing in Ears	__________
Women: Are you pregnant?	________		