

PATIENT HISTORY UPDATE

PERSONAL INFORMATION

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Cell Phone _____ Work Phone _____ Email _____
Employer _____ Address _____
City: _____ State _____ Zip _____

INSURANCE INFORMATION:

Has your insurance changed since last visit? Yes No

If yes, please have office staff make a copy of your new insurance card

HISTORY UPDATE

What is your major complaint? _____

Surgeries since your last visit (type and date): _____

Traumas, Injuries or Auto Accidents since your last visit: _____

Illnesses or Hospitalizations since your last visit: _____

New medications or changes in medications since your last visit: _____

Last Physical Examination: _____

Since my last visit, I have seen other doctors for: _____

Additional Comments: _____

Patient's Signature _____ Date _____
(Legal Guardian, If Minor)

PAST MEDICAL HISTORY: Place an "X" next to conditions that you currently or previously experience(d).

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Acid reflux or ulcers | <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Low blood sugar |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Headaches or migraine | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Arm pain | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Neurological problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Colon problems | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma or Bronchitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Herniated disk | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Kidney or bladder disease | <input type="checkbox"/> Stroke or TIA |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Blood vessel disease | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver or gallbladder | <input type="checkbox"/> Other _____ |

Next to each symptom that you are **currently** experiencing, identify how often the symptom occurs by placing either an O = Occasional (Off and On), F = Frequent (Most of the time), or C = Constant (All of the time)

HEAD

- Headache
- Sinus (allergy)
- Entire Head
- Back of Head
- Forehead
- Temples
- Migraine
- Loss of Memory
- Light-Headedness
- Fainting
- Light Bothers Eyes
- Blurred Vision
- Double Vision
- Loss of Vision
- Loss of Taste
- Loss of Balance
- Dizziness
- Loss of Hearing
- Pain in Ears
- Ringing in Ears

NECK

- Neck Pain
- Neck Stiffness
- Muscle Spasms
- Grinding Sounds
- Popping Sounds
- Neck Pain with movement:
 - Forward
 - Backward
 - Turn to Right
 - Turn to Left
 - Bend to Right
 - Bend to Left

UPPER EXTREMITIES

- Shoulder Pain
- Tension in Shoulders
- Rotator Cuff Problems
- Difficult To Raise Arm
- To Shoulder Level
- Above Shoulder Level

- Pain in Upper Arm
- Elbow Pain
- Pain in Forearm
- Pain in Hands
- Pain in Fingers
- Numbness or Tingling in Arm
- Numbness or Tingling in Hands/Fingers
- Cold Hands
- Fingers go to Sleep
- Swollen Finger Joints
- Sore Finger Joints
- Arthritis in Fingers
- Loss of Grip Strength

UPPER BACK

- Upper Back Pain
- Pain between Shoulder Blades
- Pain from Front to Back

LOWER BACK

- Low Back Pain
- Muscle Spasms
- Herniated Disk
- Aggravated By:
 - Working
 - Lifting
 - Standing
 - Sitting
 - Bending
 - Coughing/Sneezing
 - Lying Down
 - Walking
- Other _____

LOWER EXTREMITIES

- Relieved By _____
- Pain in Buttocks
- Pain in Hip
- Leg Pain

- Knee Pain
- Leg Cramps
- Cramps in Feet
- Numbness or Tingling in Legs
- Numbness or Tingling in Feet/Toes
- Ankle Pain
- Foot Pain
- Swollen Ankles
- Swollen Feet
- Cold Feet

CHEST:

- Chest Pain
- Shortness of Breath
- Pain Around Ribs
- Breast Pain
- Dimpled Breast
- Irregular Heartbeat

ABDOMEN:

- Upset Stomach
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids
- Problem Foods _____

WOMEN ONLY

- Are You Pregnant? _____
- Menstrual Pain/Cramps
- Irregular Cycle
- Discharge
- Birth Control (Type) _____
- Hysterectomy (when) _____
- Cancer/Type: _____
- Menopause _____
- Tumors _____
- Abortions _____

MEN ONLY

- Frequent Urination
- Difficulty in Starting
- Night Urination
- Prostate Problems
- Cancer/Type: _____

GENERAL

- Nervousness
- Irritable
- Depressed
- Fatigue
- Frequent Colds/Flu
- Weight Loss _____ pounds
- Weight Gain _____ pounds

HEALTH HABITS

- Tobacco:**
- Cigarettes # / day _____
- Cigars # / day _____
- Alcohol:**
- Wine #glasses/d or wk _____
- Beer #glasses/d or wk _____
- Liquor #ounces/d or wk _____
- Caffeine:**
- Coffee #6 oz cups/d _____
- Tea #6 oz cups/d _____
- Soda cans/d _____
- Other sources _____
- Water:** # glasses/d _____

EXERCISE

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more
- 30-45 minutes
- Less than 30 minutes
- Walk _____
- Run/Jog _____
- Weight lift _____
- Swim _____
- Bike _____
- Other _____