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Initial Visit History

Where on your body is the problem? _____

Describe the problem, please circle the applicable symptom:

Please give a brief history of how
problem occurred:

Quality of pain - sharp dull throbbing aching shooting

Severity of pain - minor moderate severe

Duration - intermittent constant lasting minutes hours days

Onset - when did the pain begin? _____

Timing - with certain activities at night only

Context - worsening plateaued improving

Modifying factors - rest heat ice elevation medications therapy
Do they help? _____

Associated signs and symptoms - bruising numbness weakness tingling

Have you had any of the following? If yes, please check and describe briefly.

- | | | | | | |
|---|--|---|--------------------------------------|---------------------------------------|--------------------------------|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Chills | <input type="checkbox"/> Other Bone | <input type="checkbox"/> Joint | <input type="checkbox"/> Muscle Pains | |
| <input type="checkbox"/> Sinus | <input type="checkbox"/> Mouth | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Birth marks | <input type="checkbox"/> Burns | <input type="checkbox"/> Scars |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Chest Pain | | | |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Numbness | | | |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Low Blood Count | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Bleeding | | | |
| <input type="checkbox"/> Menopause | <input type="checkbox"/> Taking Hormones | <input type="checkbox"/> Skin or Eyes Turn Yellow | | | |
| <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Problems with Frequent Infections | | | | |

Patient Date of Birth _____ Age _____ Height _____ Weight _____

Patient Name _____ Date _____

List all past and present medical problems:

List current medications and dosages for each condition:

List year and reason for all hospitalizations excluding surgery:

List all surgeries, the years they were performed and which hospital:

List allergies and describe your reaction (for example, penicillin - rash)

Marital Status M S W D

Occupation, present or former if retired _____

Hobbies or Activities _____

Family History and Relationship:

 Hereditary disorders

 Cancer

 Heart disease

 Diabetes

 High blood pressure

 Lung disease

How much and what type of the following do you use per day?

Tobacco _____

Drugs _____

Alcohol _____

Caffeine _____