Name_____Age_____DOB_____

☐ Right Handed ☐ Left Handed

Reason for Visit_____

Social History

☐ Married ☐ Single ☐ Partner Same/Opposite ☐ Divorced ☐ Widowed

Cigerettes/Cigars ☐ Yes ☐ No _____Packs per day
Alcohol ☐ Yes ☐ No _____drinks per day_____per week
Recreational Drugs ☐ Yes ☐ No name_____
Caffeinated beverages ☐ Yes ☐ No _____per day

What type of work do you do?_____ Do you do any heavy lifting at work? ☐ Yes ☐ No

Are you currently disabled? ☐ Yes ☐ No

List any allergies to medications, IV dye, or foods_____

Family History (list blood relative)

☐ Epilepsy _____ ☐ High Cholesterol_____ ☐ Alcoholism_____
☐ Migraine_____ ☐ Heart Disease_____ ☐ Genetic Disease_____
☐ Mental illness_____ ☐ Stroke_____ ☐ Cancer_____
☐ Diabetes_____ ☐ Neuropathy _____ ☐ Tremor_____
☐ Parkinson's_____ ☐ Alzheimer's_____ ☐ Multiple Sclerosis_____
☐ Neuropathy_____ ☐ High Blood Pressure_____

Previous Hospitalizations
Year_____Illness/operation_____Where_____
Year_____Illness/operation_____Where_____

List any prior significant injuries_____ How Long?_____

System Review / Past Medical History (Check problems you have now or in the past)					
General	**Musculoskeletal**	**Neurologic**	☐ Mental Illness	**Skin**	**Endocrine**
☐ Weight Loss	☐ Osteoporosis	☐ Convulsion/seizure	**Cardiovascular**	☐ Rashes	☐ Diabetes
☐ Weight Gain	☐ Muscle Weakness	☐ Stroke	☐ Chest pain/tightness	☐ Hives	☐ Thyroid Disease
☐ Cancer	☐ numbness/ Tingling	☐ Headaches-severe	☐ Heart murmur	**Gastrointestinal**	☐ (Female) Day of last period _____
☐ Excessive Thirst	☐ Arthritis	☐ Migraine	☐ Irregular pulse	☐ Loss Of appetite (recent)	**Head, Ears, Nose, Throat**
☐ Fever	☐ Back Pain	☐ Tremor/shaking	☐ High Blood Pressure	☐ Difficult to swallow	☐ Sinus Pain
☐ fatigue	☐ Joint injury/Gout	**Genitourinary**	☐ High Cholesterol	☐ Indigestion	☐ Hoarseness
Eyes	**Respiratory**	☐ No bladder control	☐ Palpitations	☐ nausea/vomiting	☐ Decreased hearing
☐ Failing vision	☐ Asthma/chronic cough	☐ Venereal Disease	**Hematology**	☐ Peptic ulcer	☐ Ringing in the ears
☐ Eye pain	☐ Pneumonia/Pleurisy	**Psychiatric**	☐ Anemia	☐ Abdominal Pain	**Sleep**
☐ double or blurred	☐ Bronchitis/Emphysema	☐ Nervousness	☐ Bruise easily	☐ Jaundice/hepatitis	☐ sleeping difficulty
☐ Glaucoma	☐ Shortness of Breath	☐ Depression	☐ contact with bodily fluids	☐ Diarrhea	☐ snoring
☐ Cataracts	☐ Wheezing	☐ Memory Loss	☐ Exposure to HIV	☐ Constipation	

Patient Name_____

Please List all current medications including non-prescriptions.

Please List all current medications including non-prescriptions.					
Name	**Dosage**	**Name**	**Dosage**	**Name**	**Dosage**

List any allergies to medications, IV dye, or foods_____

Please check Chronic/current illness		
☐ Asthma	☐ Substance Use	☐ Neuropathy
☐ Hypertension	☐ ADHD	☐ Multiple Sclerosis
☐ Diabetes	☐ Alzheimer's	☐ Myastenia Gravis
☐ Coronary Disease	☐ Dementia	☐ Dystonia
☐ Cardiac arrythmias	☐ Epilepsy	☐ Other List Below
☐ Peripheral vascular Disease	☐ Seizure disorder	☐
☐ Hyperlipidemia	☐ Migraine	☐
☐ Thyroid Disease	☐ Headaches	☐
☐ Depression	☐ Cluster Headache	☐
☐ Schizophrenia	☐ Stroke	☐
☐ Bipolar Disorder	☐ Parkinson's	☐
☐ Personality Disorder	☐ Guillian Barre	☐