MEDICAL AND SOCIAL HISTORY

Date: ________________ Patient Name: ____ Date of Birth: _____________ Age: ________

☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Please list your current symptoms: ____

____

Past tests/treatments for these symptoms: ☐ Therapies ☐ Chiropractic Treatment ☐ Epidural Blocks MRI: ☐ Head ☐ Spine CT: ☐ Head ☐ Spine ☐ Myelogram ☐ EMG/Nerve Conduction

List any past surgeries or hospitalizations you have had including dates: ________________________________

____

Past Medical History: Please check yes / no if you have been **diagnosed with or treated for** the following disorders. ***Please explain all "yes" answers on reverse side.***

CARDIOVASCULAR

Y N

- ☐ ☐ congestive heart failure
- ☐ ☐ cardiovascular disease
- ☐ ☐ angina (ischemic chest pain)
- ☐ ☐ arrhythmia (irregular heart rate/rhythm)
- ☐ ☐ high blood pressure
- ☐ ☐ murmur
- ☐ ☐ increased cholesterol
- ☐ ☐ peripheral vascular disease
- ☐ ☐ other ________________

RESPIRATORY

Y N

- ☐ ☐ COPD
- ☐ ☐ asthma
- ☐ ☐ other ________________

MUSCULOSKELETAL

- ☐ ☐ arthritis
- ☐ ☐ fibromyalgia
- ☐ ☐ gout
- ☐ ☐ other ________________

GASTROINTESTINAL

Y N

- ☐ ☐ gastric reflux
- ☐ ☐ bowel disorder __________
- ☐ ☐ ulcers
- ☐ ☐ other ________________

ENDOCRINOLOGY

- ☐ ☐ hypothyroidism
- ☐ ☐ hyperthyroidism
- ☐ ☐ diabetes
- ☐ ☐ other ________________

HEMATOLOGY/ONCOLOGY

Y N

- ☐ ☐ cancer ________________
- ☐ ☐ bleeding disorders
- ☐ ☐ anemia
- ☐ ☐ other ________________

NEUROLOGICAL DISORDERS

- ☐ ☐ stroke
- ☐ ☐ seizures
- ☐ ☐ peripheral neuropathy
- ☐ ☐ brain mass
- ☐ ☐ other ________________

Are you a smoker? ☐ Yes ☐ No If so, how long?______________ How much?_________ If quit, when? __________________

Do you drink alcohol? ☐ Never ☐ On Occasion ☐ Moderately Are you ☐ Left Handed ☐ Right Handed

Family History: Please list any medical problems or diseases in your family:

____

____

Please mark yes or no if you have had the following **symptoms** in the past 6 months.

CONSTITUTIONAL

Y N

- ☐ ☐ considerable weight loss
- ☐ ☐ easy fatigue

EYES

Y N

- ☐ ☐ glasses
- ☐ ☐ contacts
- ☐ ☐ double vision
- ☐ ☐ glaucoma
- ☐ ☐ cataracts

EAR, NOSE & THROAT

Y N

- ☐ ☐ difficulty hearing
- ☐ ☐ ringing in ears
- ☐ ☐ dizziness
- ☐ ☐ sinus trouble
- ☐ ☐ frequent sore throats
- ☐ ☐ hoarseness

CARDIOVASCULAR

Y N

- ☐ ☐ chest pain
- ☐ ☐ palpitations
- ☐ ☐ fainting spells
- ☐ ☐ shortness of breath
- ☐ ☐ swelling ankles or hands

RESPIRATORY

Y N

- ☐ ☐ constant cough
- ☐ ☐ coughing blood
- ☐ ☐ wheezing
- ☐ ☐ chills

GASTROINTESTINAL

Y N

- ☐ ☐ heartburn
- ☐ ☐ nausea-vomiting
- ☐ ☐ constipation
- ☐ ☐ diarrhea
- ☐ ☐ difficulty swallowing
- ☐ ☐ jaundice
- ☐ ☐ abdominal pain

GENITOURINARY

Y N

- ☐ ☐ pain urinating
- ☐ ☐ burning when urinating
- ☐ ☐ frequency of urination
- ☐ ☐ blood in urine
- ☐ ☐ difficulty urinating
- ☐ ☐ kidney stones

MUSCULOSKELETAL

Y N

- ☐ ☐ joint pain-swelling
- ☐ ☐ stiffness / arthritis
- ☐ ☐ muscle pain
- ☐ ☐ back pain
- ☐ ☐ neck pain
- ☐ ☐ leg pain
- ☐ ☐ arm pain

NEUROLOGICAL

Y N

- ☐ ☐ seizures
- ☐ ☐ weakness-paralysis
- ☐ ☐ numbness
- ☐ ☐ tremors
- ☐ ☐ memory loss
- ☐ ☐ headaches, chronic

ENDOCRINE

Y N

- ☐ ☐ loss of hair
- ☐ ☐ heat or cold intolerance

LIST ALL MEDICATIONS ON REVERSE SIDE

Patient Signature: ____ Date: ____________________

Physician Reviewed: ____ Date: ____________________

PLEASE EXPLAIN ALL "YES" ANSWERS FROM FRONT SIDE

PLEASE PRINT

(Attach list if you need more space)

MEDICATION/ PRESCRIPTION OVERTHE COUNTER	DOSAGE MG	FREQUENCY #TIMES/DAY	REASON/CONDITION TREATED	PRESCRIBING DOCTOR

LIST ALLERGIES ______________________________

PHARMACY PHONE NUMBER ______________________________

DATE ______________________________