PATIENT HISTORY

Office Imprint
or
Business Card Here

Patient Name _____ Date _____
Date of Birth _____ Sex _____ Marital Status _____
Telephone Numbers/Home ( )_____Work ( ) _____
Home Address _____
Street _____
City _____ State _____ Zip _____

General Health Review

Medical History (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illnesses, etc.)

_____ _____ _____
_____ _____ _____

Surgical History (**unrelated** to pain; such as appendectomy)

_____ _____ _____
_____ _____ _____

Surgical History (**related** to pain; such as laminectomy)

_____ _____ _____
_____ _____ _____

Allergies (include medication and food allergies)

_____ _____ _____
_____ _____ _____

Intolerances (include side effects from previous medications, such as gastritis, nausea, constipation, etc.)

_____ _____ _____
_____ _____ _____

Current Medications (include vitamins and birth control pills, if applicable)

_____ _____ _____
_____ _____ _____

Do you have any of the following? (Circle all that apply)

Headaches	Stomach Pain	Chest Pain
Vision Problems	Nausea	Shortness of Breath
Hearing Problems	Vomiting	Urinary Problems
Dizziness	Constipation	Rashes
Difficulty Swallowing	Diarrhea	Swollen Joints
		Chronic Fatigue

Domestic Situation

With whom do you live? _____

Are there any substance abuse issues in the household? Yes____ No____

If yes, please explain _____

Are you able to take care of yourself? Yes____ No____

If not, please enter name of caregiver _____

Work History

Job Years worked Why did you leave?

_____

_____

Legal Matters

Are you presently involved in a lawsuit? Yes____ No____ If yes, please explain.

_____

_____

Substance Use

Which of the following drugs or substances, if any, have you used in the <u>past</u>? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you used it occasionally ("O"), frequently ("F"), or continuously ("C").

Alcohol _____	Barbiturates _____	Cocaine _____
Heroin _____	Amphetamines____	Marijuana _____
Other _____	Other _____	Other _____
(specify)	(specify)	(specify)

Are you presently using any of the drugs or substances below? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you use it occasionally ("O"), frequently ("F"), or continuously ("C").

Alcohol _____	Barbiturates _____	Cocaine _____
Heroin _____	Amphetamines____	Marijuana _____
Other _____	Other _____	Other _____
(specify)	(specify)	(specify)

Do you presently smoke cigarettes or use tobacco in any form? Yes____ No____

If not, did you ever smoke cigarettes or use tobacco in any form? Yes____ No____

How many packs do (did) you smoke a day? ____ For how many years? ____