NAME:_____

NEUROLOGICAL

Stroke/TIA □Yes □No
Paralysis/Gait Abnormality □Yes □No
Seizures □Yes □No
Memory Loss □Yes □No
Headaches □Yes □No
Head Injury □Yes □No
Depression □Yes □No
Anxiety □Yes □No
Fainting □Yes □No
History of falls in past year □Yes □No
(if yes, how many)
_____ times
Restless Leg Syndrome □Yes □No

GASTROINTESTINAL

Pain w/ eating □Yes □No
Acid reflux/heartburn □Yes □No
Peptic Ulcers/GI Bleed □Yes □No
Hepatitis/Liver disease □Yes □No
Motion sickness □Yes □No
Recent weight loss/gain □Yes □No
_____ lbs
Abdominal pain □Yes □No

ENDOCRINE

Hypoglycemia □Yes □No
Diabetes □Yes □No
(if yes, how controlled?)
□ Diet □ Oral Med □Insulin
Hyperthyroidism □Yes □No
Hypothyroidism □Yes □No
Absent/Irregular period □Yes □No

BLOOD DISORDERS/HEMATOLOGY

HIV/AIDS □Yes □No
Blood transfusion □Yes □No
Date: _____

CANCER/MALIGNANCY

Family history of cancer □Yes □No
Type: _____
Cancer □Yes □No
Type: _____
Radiation □Yes □No
Date: _____
Chemotherapy □Yes □No
Date: _____

UROLOGICAL/KIDNEY

Kidney Disease □Yes □No
Dialysis/IV therapy/Drug use □Yes □No
Prostate disease □Yes □No
Urination problem/incontinence □Yes □No
Medication for urination problem □Yes □No
Please list:_____
_____times/day

MUSCULOSKELETAL

Artificial joint replacement or metal implanted devices □Yes □No
History of corticosteroid use □Yes □No
History of or current episode of □Yes □No
□ osteoporosis
□ osteopenia
History of trauma/fracture □Yes □No
Arthritis □Yes □No
location: _____
Pain/paresthesias □Yes □No
TMJ/jaw pain □Yes □No

HEART/CARDIOVASCULAR

Family history of cardiovascular disease □Yes □No
Heart attack □Yes □No
Angina/chest pain □Yes □No
High blood pressure □Yes □No
Congestive heart failure □Yes □No
Irregular heartbeat □Yes □No
Heart murmur/valve □Yes □No
Rheumatic heart fever □Yes □No
Swelling of the feet □Yes □No
Abnormal sensations w/ exertion □Yes □No
(if yes, location)
□ Chest □ Arms □ Neck
Date of last event: _____
Can you walk 2 flights of stairs w/o stopping? □Yes □No
Implanted Defibrillator □Yes □No
High cholesterol/lipids □Yes □No
Pacemaker □Yes □No
Last battery check: _____
Angioplasty/stent □Yes □No
Date: _____

Please continue to the next page…

NAME:_____

LUNG/PULMONARY

Emphysema/COPD □Yes □No

Snoring □Yes □No

Sleep Apnea □Yes □No

Recent cold/flu/fever □Yes □No

Chills/night sweats □Yes □No

Pneumonia □Yes □No

Blood clot □Yes □No

□Lungs □Legs

Date:_____

Chronic cough □Yes □No

Shortness of breath □Yes □No

Usage of CPAP device □Yes □No

OTHER

Pregnant □Yes □No

Weeks: _____

Use of NSAIDS □Yes □No

Type:_____ _____/day

Allergies □Yes □No

Type:

Tobacco use □Yes □No

Duration: _____

Frequency: _____

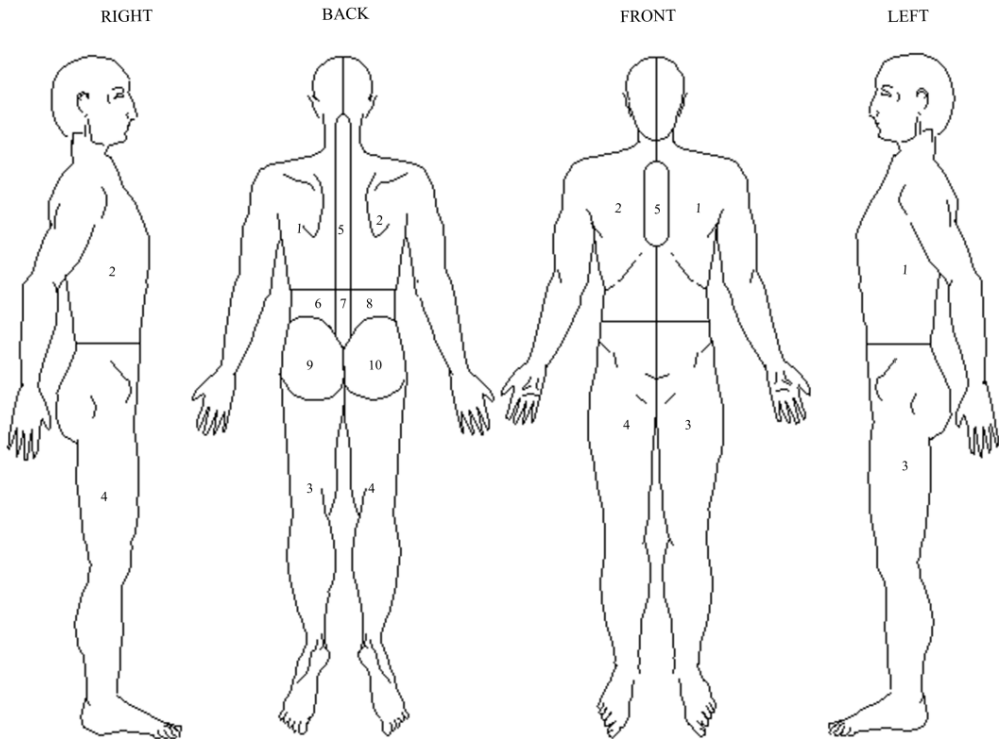
Alcohol Consumption □Yes □No

(if yes, how many per week?

_____/week

LIST OF SURGERIES:

****Please use the KEY to indicate your pain on the chart below****



KEY:

PAIN	×
TIGHTNESS	✓
JOINT STIFFNESS	○
SWELLING	○
TINGLING	⋆
NUMBNESS	➢

****Please use the scale and rate your pain at its WORST/BEST/CURRENT:

PAIN MEASUREMENT SCALE