

Name: _____

Visit Date: _____

REVIEW OF SYSTEMS: (Do you currently have any of the following medical symptoms:)

- Abnormal Bleeding: Yes / No
- Abnormal Menstrual Cycle: Yes / No
- Balance Problems: Yes / No
- Chest Pain: Yes / No
- Cold Hands / Feet: Yes / No
- Constipation: Yes / No
- Cough: Yes / No
- Depression: Yes / No
- Ear Pain: Yes / No
- Fainting: Yes / No
- Fever: Yes / No
- Growth Disturbance: Yes / No
- Impotence: Yes / No
- Incontinence of Bowel: Yes / No
- Incontinence of Urine: Yes / No
- Loss of Appetite: Yes / No
- Mania: Yes / No
- Muscle Weakness: Yes / No
- Nausea: Yes / No
- Numbness of Hands: Yes / No
- Numbness of Feet: Yes / No
- Runny Nose: Yes / No
- Seizures: Yes / No
- Shortness of breath: Yes / No
- Skin Rash: Yes / No
- Skin Ulcer: Yes / No
- Sleep Disturbance: Yes / No
- Sore Throat: Yes / No
- Sputum Production: Yes / No
- Stomach Pain: Yes / No
- Swelling in Legs: Yes / No
- Visual Disturbance: Yes / No
- Vomiting: Yes / No
- Weight Gain: Yes / No
- Unexplained Weight Loss: Yes / No
- Wheezing: Yes / No

Other: _____

- Are you independent in normal daily activities? Yes / No
- Has this changed recently? Yes / No

Thank you for taking the time to complete this Health History and Medical Assessment.

Form Reviewed on: _____

By: _____

PAST MEDICAL HISTORY: (Do you have any of the following medical problems:)

- AIDS / HIV: Yes / No
- Anemia: Yes / No
- Arthritis: Yes / No
- Bleeding Probs: Yes / No
- Cancer: Yes / No
- Diabetes: Yes / No
- Depression: Yes / No
- Emphysema: Yes / No
- Epilepsy: Yes / No
- Fibromyalgia: Yes / No
- Gout: Yes / No
- Headaches: Yes / No
- Heart Probs: Yes / No
- Hepatitis: Yes / No
- Hypertension: Yes / No
- Kidney problems: Yes / No
- Migraines: Yes / No
- Muscle Diseases: Yes / No
- Nerve Probs: Yes / No
- Osteoporosis: Yes / No
- Pneumonia: Yes / No
- Polio: Yes / No
- Psych Disorders: Yes / No
- Stomach Probs: Yes / No
- Stroke: Yes / No
- Thyroid Probs: Yes / No

Other: _____

PAST SURGICAL HISTORY: (Please list any previous surgeries and the dates:)

FAMILY HISTORY: (Does any member of your family have a history of:)

- AIDS/HIV: Yes / No
- Anemia: Yes / No
- Arthritis: Yes / No
- Bleeding Probs: Yes / No
- Cancer: Yes / No
- Depression: Yes / No
- Diabetes: Yes / No
- Emphysema: Yes / No
- Epilepsy: Yes / No
- Fibromyalgia: Yes / No
- Gout: Yes / No
- Heart Probs: Yes / No
- Hepatitis: Yes / No
- Hypertension: Yes / No
- Migraines: Yes / No
- Headaches: Yes / No
- Kidney Probs: Yes / No
- Muscle Diseases: Yes / No
- Nerve Probs: Yes / No
- Osteoporosis: Yes / No
- Pneumonia: Yes / No
- Psych Disorders: Yes / No
- Stomach Probs: Yes / No
- Stroke: Yes / No
- Thyroid Probs: Yes / No

Other: _____

SOCIAL HISTORY:

- Marital Status: Single/Married/Divorced/Widowed
- Do you smoke? Yes / No
- If yes, Amount: _____ per day/week
- Do you drink alcohol? Yes / No
- If yes, Amount: _____ per day/week
- Do you or have you used recreational drugs? Yes / No

If yes, Type: _____



Name:

Date:

Age:

Initial Visit _____ Follow up _____

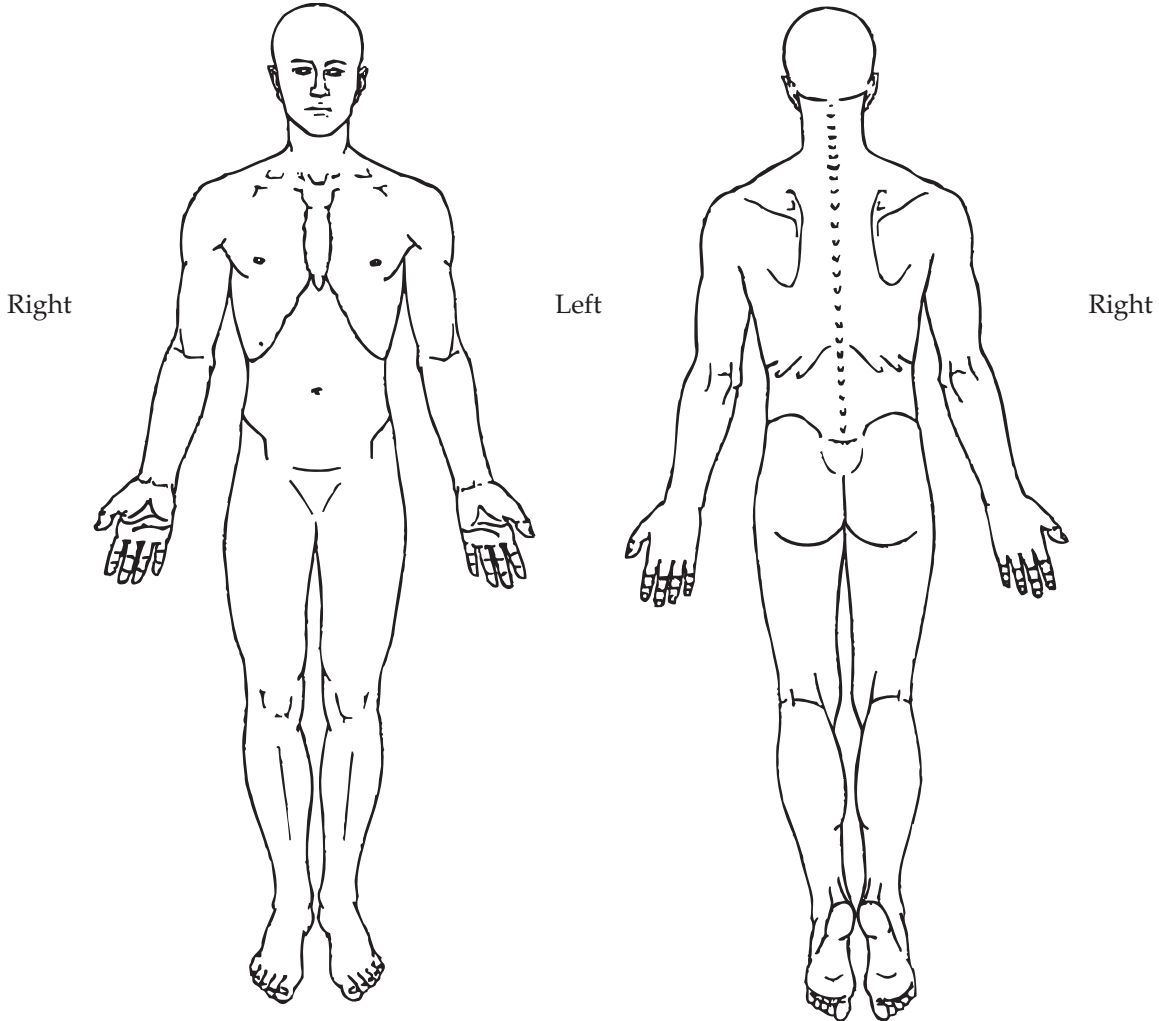
Preprocedure _____ Postprocedure _____

PAIN DRAWING

Instructions:

Mark these drawings according to where you hurt (i.e., if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

Key: Stabbing /// Burning XXX Pins & Needles 000 Numbness === Aching +++



Pain Level:

0 1 2 3 4 5 6 7 8 9 10
 (Check the worst & best it's been and circle your current pain level.)

Key:

- 0 No Pain.
- 1 Mild pain; you are aware of it, but it doesn't bother you.
- 2 Moderate pain that you can tolerate without medication.
- 3 Moderate pain that requires medication to tolerate.
- 4-5 More severe pain; you begin to feel antisocial.
- 6 Severe pain.
- 7-9 Intensely severe pain.
- 10 Most severe pain.