

PATIENT HEALTH INFORMATION

Name _____ Date of Birth _____ Age _____ Height _____ Weight _____ Sex **M F**

What is your major complaint? _____

Have you seen another doctor for this condition? **Y N** Where & When? _____

How long have you had this condition? _____ Have you had this before? **Y N** Is it : **Better Worse Same**

Is this due to an auto accident or job related injury? **Y N** If Yes, are you currently in a lawsuit or litigation? **Y N**

Is this condition interfering with your : **Work Sleep Daily Activities**

Are you taking any medication? **Y N** Pain relievers? **Y N**

Yes	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Any illness or injury in the last 2 years	<input type="checkbox"/>	<input type="checkbox"/>	Loss of or altered consciousness
<input type="checkbox"/>	<input type="checkbox"/>	Head/ Brain Disorder or illness	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Ear, Nose, Throat, Mouth diseases	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring, sleep apnea
<input type="checkbox"/>	<input type="checkbox"/>	Skin diseases or Breast lumps or lesions	<input type="checkbox"/>	<input type="checkbox"/>	Stroke or paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Sudden or unusual weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Missing or impaired hand, arm, foot, leg, finger, toe
<input type="checkbox"/>	<input type="checkbox"/>	Seizures, epilepsy, convulsions, fainting	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling of arms, legs, hands, or feet
<input type="checkbox"/>	<input type="checkbox"/>	Eye disorders or impaired vision (Except corrective lenses)	<input type="checkbox"/>	<input type="checkbox"/>	Spinal injury or disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease or heart attack; other than Cardiovascular condition	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or ongoing low back pain
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Narcotic or habit forming drug use
<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease/joint pain/ carpal tunnel syndrome/tendonitis/arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Regular, frequent alcohol use
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Any other disease or illness _____
<input type="checkbox"/>	<input type="checkbox"/>	Lung disease, emphysema, asthma, chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Do you have and cancer or illness that tends to occur in you family? If yes, list: _____
<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems/Ulcers/Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, epilepsy, convulsions, fainting
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or elevated blood sugar controlled by: <input type="checkbox"/> Diet <input type="checkbox"/> Pills <input type="checkbox"/> Insulin	<input type="checkbox"/>	<input type="checkbox"/>	Nervous or psychiatric disorders <input type="checkbox"/> Medication

For any **YES** answer, indicate onset date, diagnosis, treating physician's name and address, any current limitations. List all medications (including over the counter medications) used regularly or recently. _____

List any past surgeries/operations/hospitalizations: _____

List any allergies: _____

Are your parents deceased, if so why: _____

Are your siblings deceased, if so why: _____

I certify that the above information is complete and true. I understand that inaccurate, false, or missing information may invalidate the examination.

Signature: _____

Date: _____