|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | Logo  Description automatically generated |  |  |
|  |  |  |  |  |  |  |
| Name:  |   |   |   |   |   |
| Main Pain Complaint for Today's Visit: |   |   |   |   |
| Other Pain Complaints: |   |   |   |   |
|  |   |   |   |   |   |   |
|  |   |   |   |   |   |   |
| **PHARMACY** Name/Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **MEDICATIONS:** List all medications that you take, including any supplements, with their doses and frequency. |
|  | 1 |   | 7 |   | 13 |   |
|  | 2 |   | 8 |   | 14 |   |
|  | 3 |   | 9 |   | 15 |   |
|  | 4 |   | 10 |   | 16 |   |
|  | 5 |   | 11 |   | 17 |   |
|  | 6 |   | 12 |   | 18 |   |
| **ALLERGIES:** List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you. |
|  | 1 |   | 4 |   | 7 |   |
|  | 2 |   | 5 |   | 8 |   |
|  | 3 |   | 6 |   | 9 |   |
| **PAST MEDICAL HISTORY:** Please indicate if you have any of the following medical contions. |  |
|  |   | AIDS or HIV |   | Fibromyalgia |   | Seizures/Convulsions |
|  |   | Congestive heart failure |   | Gout |   | Shingles |
|  |   | Asthma |   | Osteoporosis |   | Stroke |
|  |   | COPD/Emphysema |   | Headaches/migraines |   | Thyroid Disease |
|  |   | Sleep Apnea |   | Coronary Artery Disease |   | Urinary Infection |
|  |   | Renal (kidney) Insufficiency |   | Heart Murmur |   | Hepatitis |
|  |   | Dialysis |   | High Blood Pressure |   | DVT/Pulmonary Embolism |
|  |   | Cancer (If so what kind/when?) |   | Liver Disease |   | Kidney Stones |
|  |   |   |   | Lupus/Autoimmune Disease |   | Tuberculosis |
|  |   | Depression |   | Multiple Sclerosis |   | Leg/Foot Ulcers |
|  |   | Diabetes |   | Anxiety Disorder |   | High Cholesterol |
|  |   | Bleeding Disorder |   | Reflux/Ulcers |   | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |   | Heart Arrythmia |   | Peripheral Vascular Disease |  |   |
|  |   | Pacemaker |   | Schizophrenia/Bipolar |  |   |
|  |  |  |  |  |  |  |
| **PAST SURGICAL HISTORY:** Please indicate year and kind of surgery. |  |  |
|  | 1 |   | 4 |   | 7 |   |
|  | 2 |   | 5 |   | 8 |   |
|  | 3 |   | 6 |   | 9 |   |
| **FAMILY HISTORY:** Please list diseases or illnesses in your immedicate family (parents, grandparents, children) |
|  | 1 |   | 4 |   | 7 |   |
|  | 2 |   | 5 |   | 8 |   |
|  | 3 |   | 6 |   | 9 |   |
| **SOCIAL HISTORY** |  |  |  |  |
|  | Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Live With:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Smoker? YES/NO Pack(s)/Day?\_\_\_\_ Years?\_\_\_\_Alcohol? YES/NO What kind/how much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Dominate Hand: LEFT/RIGHT Education:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Illicit Drug History? YES/NO What kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Most recent use?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | History of abusing, misusing, diverting, overdosing on or being addicted to prescription drugs. YES/NO |
|  | If YES, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |   |   |   |   |   |   |
|  |   |   |   |   |   |   |
| **REVIEW OF SYSTEMS:** Have you experienced any of the following recently? (please circle) |  |
|  | GENERAL: Fevers, chills, night sweats, unexplained weight loss |  |  |
|  | EYES: Blurred vision, loss of vision, double vision, eye pain |  |  |
|  | HEENT: Hoarseness, trouble swallowing, hearing loss, ear pain |  |  |
|  | CARDIOVASCULAR: Chest pain, leg swelling, palpitations, heart murmur |  |  |
|  | RESPIRATORY: Sleep apnea, COPD, asthma, chronic bronchitis |  |  |
|  | GASTROINTESTINAL: Nausea, vomiting, diarrhea, constipation, blood in stool, abdominal pain |
|  | KIDNEY/BLADDER: Painful urination, blood in urine |  |  |
|  | MUSCULOSKELETAL: Joint pain, muscle pain, stiffness |  |  |
|  | SKIN: Itching, redness, rash |  |  |  |  |
|  | NEUROLOGICAL: New weakness, new numbness, new loss of coordination, new urinary incontinence, |
|  |  | new bowel incontinence |  |  |  |  |
|  | PSYCHIATRIC: Depression, anxiety, alcohol addiction, drug abuse, use of illegal drug, use of  |
|  |  | prescription medication for non-medical reason, recent substance abuse treatment, craving |
|  |  | medications, difficulty controlling medication use, family or work problems related to medication |
|  |  | use, suicidal thoughts, homicidal thoughts |  |  |
|  | ENDOCRINE: Heat intolerance, cold intolerance, fatigue |  |  |
|  | HEME/LYMPH: Easy bruising, easy bleeding |  |  |  |
|  | IMMUNOLOGIC: Swollen lymph glands |  |  |  |  |