|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | 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 | |  |  |  |  |