CLINICAL HISTORY FORM

TODAY'S DATE: ____________________

NAME: ______________________________ DATE OF BIRTH: ______________________________

CHIEF COMPLAINT

JOINT PAIN JOINT SWELLING FATIGUE WEAKNESS DECREASED MOBILITY RASHES STIFFNESS FEVER OTHER: ______________________________

WHERE?
"ALL OVER"
ALL JOINTS
MANY JOINTS
ALL MUSCLES
MANY MUSCLES
JAWS
CHEST
NECK
MID BACK
LOWER BACK
LT RT SHOULDERS
LT RT ELBOWS
LT RT WRISTS
LT RT HANDS
LT RT FINGERS
LT RT HIPS
LT RT KNEES
LT RT ANKLES
LT RT FEET
LT RT TOES

HOW LONG HAVE YOU HAD THIS PROBLEM?
____

IS THE PROBLEM:
GRADUAL
INTERMITTENT
SUDDEN
FREQUENT
CONSTANT
COME AND GO

TIMING?
MORNING
AFTERNOON
EVENING
NIGHT

SEVERITY?
MILD
MODERATE
SEVERE
CHANGES IN INTENSITY

HOW DOES IT FEEL?
ACHY
BURNING
DULL
SHARP
SHOOTING
THROBBING
TINGLY
NUMB
HOT
OTHER: ______________

HOW LONG IS YOUR MORNING STIFFNESS?
< 10MIN
> 15MIN
> 30MIN
> 60MIN
> 90MIN
> 2 HRS

WORSE WITH:
SITTING
STANDING
WALKING
OVER EXERTION
STANDING UP
STRESS
PREMENSTRUAL PERIOD
COLD WEATHER
WET WEATHER
OTHER: ______________

BETTER WITH:
HEAT
ICE
REST
STRETCHING
SHOWER/BATH
ACTIVITY
MASSAGE
OTHER: ______________

CURRENT PRESCRIPTION MEDICATIONS

MEDICATION NAME	STRENGTH	QUANTITY TAKEN	TIMES PER DAY
(EXAMPLE) PREDNISONE	5 MG	2 TABLETS	3 TIMES PER DAY

OVER THE COUNTER MEDICATIONS/NUTRITIONAL SUPPLEMENTS/VITAMINS

MEDICATION NAME	STRENGTH	QUANTITY TAKEN	TIMES PER DAY

PAST MEDICAL HISTORY

MUSCULOSKELETAL:
ANKYLOSING SPONDYLITIS
SCOLIOSIS
SCIATICA
CERVICAL DISC DISEASE
LUMBAR DISC DISEASE
LOW BACK PAIN
TMJ
VASCULITIS
CARPAL TUNNEL
BEHCET'S
RAYNAUDS
NEUROMAS
OSTEOPOROSIS
OSTEOPENIA
LOW VITAMIN D
RHEUMATOID ARTHRITIS
PSORIATIC ARTHRITIS
OSTEOARTHRITIS ANKLE/FOOT
OSTEOARTHRITIS HAND
OSTEOARTHRITIS HIP
OSTEOARTHRITIS KNEE
OSTEOARTHRITIS SHOULDER
OSTEOARTHRITIS NECK
OSTEOARTHRITIS THORACIC
OSTEOARTHRITIS LUMBAR
POLYMYALGIA RHEUMATICA
FIBROMYALGIA
LUPUS
PLANTAR FASCIITIS
BUNIONS
GOUT
COSTOCHONDRITIS
POLYMYOSITIS
SCLERODERMA
DERMATOMYOSITIS
ROTATOR CUFF DISEASE
TEMPORAL ARTERITIS
NON TRAUMATIC BONE FRACTURE

CARDIOLOGY:
ATRIAL FIBRILLATION
CHF
HIGH BLOOD PRESSURE
HTN
HEART MURMUR
HEART ATTACKS
PERICARDITIS
PERIPHERAL VASCULAR DISEASE
HIGH CHOLESTEROL
HIGH TRIGLYCERIDES

RESPIRATORY:
ASTHMA
EMPHYSEMA
COPD
PNEUMONIA
SLEEP APNEA
TB
SINUS/ALLERGIES
BRONCHITIS
INTERSTITIAL LUNG DISEASE

DERMATOLOGY:
HAIR LOSS
ECZEMA
CHRONIC HIVES
PSORIASIS

ENDOCRINE:
DIABETES
HIGH CALCIUM
THYROID DISEASE
OVERACTIVE THYROID
UNDERACTIVE THYROID

OPHTHALMOLOGY:
IRITIS
SCLERITIS
BLINDNESS
CATARACTS
GLAUCOMA
DIABETIC RETINOPATHY
RETINAL HEMORRHAGE
RETINAL DETACHMENT

GASTROINTESTINAL:
ESOPHAGEAL STRICTURE
BARRETT'S ESOPHAGUS
GERD
CELIAC DISEASE
GI BLEEDING
IRRITABLE BOWEL
COLON POLYPS
CIRRHOSIS
DIVERTICULOSIS
DIVERTICULITIS
ULCERS
ULCERATIVE COLITIS
CROHN'S COLITIS

KIDNEY:
RENAL CYST
RENAL INSUFFICIENCY
DIABETIC KIDNEY DISEASE
KIDNEY STONE
KIDNEY FAILURE

OB/GYN & GENITOURINARY:
PROSTATE DISEASE
INFERTILITY
POLYCYSTIC OVARIAN DISEASE
CHRONIC UTI
OF PREGNANCIES:__________
OF MISCARRIAGES:_________
OF LIVING CHILDREN:_______
MENOPAUSE AGE:___________

NEUROLOGICAL:
BELLS PALSY
GUILLIAME BARRE
PARKINSONS
POLIO
STROKE
SEIZURES
MIGRAINES
MULTIPLE SCLEROSIS
PERIPHERAL NEUROPATHY

INFECTIOUS DISEASES:
HEPATITIS: ○A ○B ○C
ABSCESSES
BACTERIAL ENDOCARDITIS
CELLULITIS
HIV/AIDS
MALARIA
SHINGLES
TUBERCULOSIS
OSTEOMYELITIS

PSYCHOLOGICAL:
BIPOLAR DISORDER
PERSONALITY DISORDER
OBSESSIVE COMPULSIVE DISORDER
POST-TRAUMATIC STRESS
DEPRESSION
PANIC ATTACKS
SCHIZOPHRENIA

HEMATOLOGY/ONCOLOGY:
IRON DEFICIENT ANEMIA
B12 DEFICIENT ANEMIA
ANEMIA - ALL OTHERS
OVARIAN CANCER
PROSTATE CANCER
COLON CANCER
BREAST CANCER
LUNG CANCER
KIDNEY CANCER
PANCREATIC CANCER
LYMPHOMA
LEUKEMIA
SKIN MELANOMA

OTHER PERTINENT MEDICAL HISTORY: ____
____

ALLERGIES/ADVERSE REACTIONS

MEDICATION/ALLERGY REACTION

____
____
____
____
____
____
____
____

SURGERIES WHEN?

CATARACTS________________
THYROID________________
TONSILS________________
CARPAL TUNNEL________________
SKIN CANCERS________________
APPENDIX________________
PROSTATE________________
BLADDER REPAIR________________
GALLBLADDER________________
BUNIONECTOMY________________
CERVICAL DISK________________
LUMBAR DISK________________
GASTRECTOMY________________
DIVERTICULITIS/COLON________________
HEMORRHOIDS________________
GASTRIC BYPASS________________
HIATAL HERNIA________________
HEART________________
PACEMAKER________________
HEART BYPASS________________
STENTS________________
VALVE REPLACEMENT
ARTHROSCOPIC KNEE: O L__________ O R________
TOTAL HYSTERECTOMY________________
PARTIAL HYSTERECTOMY________________
 # OF OVARIES REMOVED: O 1 O 2________
HIP REPLACEMENT: O L______ O R________
SHOULDER REPLACEMENT: O L______ O R________
KNEE REPLACEMENT: O L______ O R________
OTHER:________________

____

IMMUNIZATIONS/VACCINATIONS

HEPATITIS B RECEIVED:________
SHINGLES RECEIVED:________
PNEUMONIA RECEIVED:________
INFLUENZA RECEIVED:________
PPD/TB TESTING RECEIVED:________
OTHER RECEIVED:________

FAMILY HISTORY WHO??

ANKYLOSING SPONDYLITIS________________
DERMATOMYOSITIS ________________
OSTEOARTHRITIS ________________
POLYMYALGIA RHEUMATICA________________
SCIATICA________________
BEHCET'S SYNDROME________________
FIBROMYALGIA________________
OSTEOPOROSIS________________
PSORIATIC ARTHRITIS________________
SYSTEMIC LUPUS ERYTHMATOSIS________________
SJOGRENS SYNDROME________________
GOUT________________
PLANTAR FASCIITIS________________
RHEUMATOID ARTHRITIS________________
TEMPORAL ARTERITIS________________
DEGENERATIVE DISC DISEASE________________
HERNIATED DISC________________
POLYMYOSITIS________________
SCLERODERMA________________
VASCULITIS________________
HIP FRACTURE ________________

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED
WIDOW DIVORCED
EDUCATION: SOME HIGH SCHOOL GED
HIGH SCHOOL DIPLOMA
SOME COLLEGE DEGREE
EMPLOYMENT: STUDENT HOMEMAKER
RETIRED UNEMPLOYED
PART TIME FULL TIME

WHAT JOB DO YOU DO? ________________
IF YOU ARE NOT WORKING NOW,
WHEN DID YOU LAST WORK? ________________
DO YOU CONSIDER YOURSELF DISABLED? YES NO
ARE YOU RECEIVING SS DISABILITY? YES NO
AS OF WHAT DATE?: ____________

HAVE YOU LIVED IN: AZ, AR, CA, IL, IN, IA, KY, LA, MN, MS, MO, NM, OH, PA, UT, WV, WI? O YES O NO
WHERE HAVE YOU TRAVELED OUTSIDE THE USA?

____

TOBACCO USE: NEVER CURRENT PREVIOUS
 # OF PACKS PER DAY: 1/2 PACK 1 PACK 2 PACKS
YEARS USED?____________
IF YOU QUIT, HOW LONG AGO?____________
ALCOHOL USE: NEVER CURRENT PREVIOUS
 # OF DRINKS: 1 2 3 >3
PER: DAY WEEK MONTH
ILLEGAL DRUG USE: NEVER CURRENT PREVIOUS
ARE YOU CURRENTLY, OR HAVE YOU PREVIOUSLY SEEN A PAIN MANAGEMENT PHYSICIAN? NO YES
WHO? ________________________________

DIAGNOSTIC TESTING

HAVE YOU HAD ANY OF THE FOLLOWING?	WHEN?	WHERE?
BONE DENSITY SCAN	______________	____
MRI	______________	____
CT SCAN	______________	____
LABWORK	______________	____

ADDITIONAL INFORMATION

WHAT TREATMENTS OR MEDICATIONS HAVE YOU TRIED IN THE PAST?

ASPIRIN
TYLENOL
ADVIL
ALEVE
PAIN MEDS
MUSCLE RELAXERS
PHYSICAL THERAPY
WATER THERAPY
EXERCISES
OTHER: _____________
____

WHAT TREATMENTS OR MEDICATIONS HAVE WORKED BEST?

____
____
____
____
____

WHICH HAND IS DOMINANT?

RIGHT LEFT

HARDWARE /METAL IN BODY:

ANEURYSM CLIPS
AORTIC CLIPS
COCHLEAR IMPLANTS
HEARING AID
NEUROTRANSMITTER
PROSTHESIS
INSULIN PUMP
FRACTURED BONES W/RODS, PLATES, SCREWS, NAILS OR CLIPS
METAL SLIVERS IN EYES
SHRAPNEL

GENERAL:

RATE YOUR DAYTIME ENERGY:______
0=FULL ENERGY, 10=EXHAUSTED

CHILLS
FATIGUE
FEVER
NIGHT SWEATS
WEIGHT GAIN
WEIGHT LOSS

OPTHALMOLOGY:

EYE PAIN
ITCHY EYES
DOUBLE VISION
RED EYES
VISION LOSS
DRY EYES

ENT:

SINUS INFECTION
EAR PAIN
MOUTH SORES
TASTE/SMELL LOSS
STUFFY NOSE
TROUBLE CHEWING
DRY MOUTH
HEARING LOSS
RINGING IN EARS

RESPIRATORY:

WHEEZING
TB – OR EXPOSURE
SHORTNESS OF BREATH
COUGH

CARDIOLOGY:

SWOLLEN LEGS/FEET
CHEST PAIN
DIZZINESS
PALPITATIONS

GASTROENTEROLOGY:

LOSS OF APPETITE
HEMORRHOIDS
NAUSEA
HEARTBURN
VOMITING
DIARRHEA
CONSTIPATION
CHANGE IN BOWEL
BLOOD IN STOOL

HEMATOLOGY/LYMPH:

EASY BLEEDING
TENDER GLANDS
SWOLLEN GLANDS

DERMATOLOGY:

HAIR LOSS
OPEN WOUNDS OR SORES
RASH

INTEGUMERY:

BLUE OR WHITE FINGERS

GENITOURINARY:

BLOOD IN URINE
INCONTINENCE
INTIMACY ISSUES
PAINFUL GENITAL ULCER
RECURRENT UTI

NEUROLOGY:

BURNING FEET
POOR CONCENTRATION
FREQUENT FALLS
LOSS OF BALANCE

RATE MEMORY:________
0=EXCELLENT, 10=VERY POOR

HEADACHE
TINGLING/NUMBNESS
TREMOR
MEMORY LOSS

PSYCHOLOGY:

ANXIETY
DEPRESSION
TROUBLE SLEEPING
HARD TO GET TO SLEEP
HARD TO STAY ASLEEP
DO YOU NAP? YES NO

WHAT WAKES YOU FROM SLEEP?

SPOUSE
CHILDREN
SNORING
BURNING FEET
PAIN
HEADACHES
HEARTBURN
NUMB HANDS
FULL BLADDER
CHOKING
STIFFNESS

RATE YOUR SLEEP:______
0=EXCELLENT, 10=POOR

RATE YOUR MORNING RESTED-NESS:_________
0=RESTED, 10=EXHAUSTED

RATE YOUR EMOTIONAL STRESS:_______________
0=NONE, 10=SEVERE

ANY OTHER ISSUES: