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MEDICAL EVALUATION

Please answer all questions. If you do not understand the question, insert a question mark. There are 5 pages. Please fill out everything to the best of your ability.

Patient Name: _____ Date: _____

Occupation: . _____ DOB:_____

PRESENT ILLNESS:

Describe your most distressing symptoms in detail:

_____

_____

_____

_____

_____

_____

- How long have your symptoms been present? _____
- Was the onset sudden or gradual? _____
- What is the location of your symptoms? _____
- Are they intermittent or constant? _____
- Frequency and duration of symptoms _____
- Progressively increasing or decreasing? _____
- Aggravating factors _____
- Relieving factors _____

PREVIOUS INVESTIGATIONS:

- X-rays/MRI/CT-Scans _____
- Blood Tests _____
- Other_____

_____

PREVIOUS DIAGNOSIS:

Date	Doctor	Diagnosis
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT MEDICATIONS:

	Dosage	Date	Side-Effects	Does It Help?	Compliance
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Have you received any other forms of treatment (diet, acupuncture, chiropractor, dietary change, etc.)? If so, have they been helpful?

_____

_____

_____

_____

_____

What is your level of understanding of the disease and expectations?

_____

_____

MEDICAL HISTORY: (check the appropriate box)

General Health: ( ) Excellent ( ) Good ( ) Fair ( ) Poor

Weight in last year: ( ) Stable ( ) Gain ( ) Loss _____Amount

Hospitalizations:

Hospital Name	Year	Reason	Treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other Medical Problems:_____

Surgical Procedures:

Hospital Name	Year	Type	Helpful or Not?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History:

__ Cancer __ Diabetes __ Glaucoma __ Mental Illness
__ Heart Disease __ High Blood Pressure __ Strokes __ Bleeding Disorders
__ Allergy/Asthma __ Arthritis __ Migraine __ Drug/Alcohol Addiction

Social History:

Work Activities: _____
Accidents, Trauma: _____
Sexual History: _____
Recent Travel: _____
AIDS, Hepatitis: _____

REVIEW OF SYSTEMS: (check the appropriate complaint)

Diseases: __ High Blood Pressure __ Diabetes __ Rheumatic Fever
__ Cancer __ Heart Disease __ Thyroid Disease
__ HIV/AIDS __ Venereal Disease

Skin: __ Rashes __ Mouth Sores __ Loss of Scalp Hair __ Psoriasis
__ Nail Changes __ Ulcers __ Color Change __ Pigmentation
__ Nodules __ Contractures __ Sun Sensitivity __ Tightening
__ Raynauds' __ Eczema/Hives __ Cold Sensitivity

Joints: __ Location _____ __ Character of Pain _____
__ Swelling __ Morning Stiffness
__ Limitation of Motion __ Redness

__ Warmth

Head/Neck:

__ Change in Voice __ Swollen Neck Glands __ Ringing Ears
__ Neck Pain __Tender Scalp __ Jaw Pain
__ Painful or Red Eyes __ Double Vision __ Deafness
__ Dryness of Mouth and Eyes __ Impaired Vision __ Hayfever/Sinus
__ Difficulty Swallowing __ Nosebleeds

Chest:

__ Cough __ Difficulty Breathing __ Chest Pain
__ Wheezing __ Pneumonia __ Asthma
__ Snoring __ Sleep Apnea __ Bronchitis
__ Pleurisy __ Bronchitis
__ TB Skin Test __ Negative __Positive
__ When was your last chest x-ray?_____

Abdomen:

__ Heartburn/Indigestion __ Abdominal Pain __ Vomiting __ Ulcers
__ Diarrhea __ Rectal Bleeding __ Blood in Stool __ Colitis
__ Constipation __ Hemorrhoids __ Hepatitis __ Jaundice

Muscle Weakness:

__ Difficulty Climbing Stairs __ Getting up from a Chair
__ Combing your Hair __ Difficulty lifting head off the pillow
__ Wasting of Muscles

Urinary:

__ Painful Urination __ Bloody or Cloudy Urine __ Impotence
__ Frequency __ Vaginal or Penile Discharge __ Urethritis
__ Prostatitis __ Stones __ Kidney Disease
__ Flank Pain

Neurologic:

__ Recurrent Headaches __ Loss of Consciousness __ Light Headedness
__ Convulsions or Seizures __ Difficulty with Memory __ Insomnia
__ Numbness of Tingling __ Hallucinations __ Disorientation
__ Stroke __ Paralysis __ Weakness

Others:

__ Fever __ Night Sweats __ Chills __ Fatigue
__ Depression __ Anxiety __ Tension __ Cramps

List allergy/reaction to Aspirin, Penicillin or any other drug. Please indicate kind of allergic reaction:

Personal: Smoke __ Yes __ No How many per day?_____
Alcohol __ Yes __ No How much?_____

Please use these additional lines for any comments you wish to make regarding your problems:

_____ _____
Patient Signature Date