



## ***Patient Information***

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Other Last Names \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex: M F

Marital Status: Married Separated Divorced Single Significant Other

Your Pharmacy Name \_\_\_\_\_ Location \_\_\_\_\_ Phone \_\_\_\_\_

## ***Contact Information***

Street Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other \_\_\_\_\_

Which phone do you prefer we use for routine contact: Home Work Cell Other

## ***Physician Information***

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address for PCP \_\_\_\_\_

Referring Physician (if not PCP) \_\_\_\_\_ Phone \_\_\_\_\_

Address for Referring Physician \_\_\_\_\_

## ***Additional Information***

Occupation: \_\_\_\_\_ Employed: Y N Income Source: \_\_\_\_\_

Distance from home to clinic: \_\_\_\_\_ (approximate miles) \_\_\_\_\_ (minutes).

**Additional Information (cont'd)**

Other Adults living in home: Yes No If Yes, who: \_\_\_\_\_

Are you currently receiving benefits from these programs or planning on applying?

Program	Applying	Receiving	Planning
Social Security	_____	_____	_____
Private Disability	_____	_____	_____
Workers Comp	_____	_____	_____
Other Disability	_____	_____	_____

Do you currently have an attorney for your pain related medical condition? Yes No  
If "yes" complete the following:

Attorney Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**Pain Management Information**

Is your current pain related to an

- Injury/Accident? Yes No If "yes" date \_\_\_\_\_
- Motor Vehicle Yes No If "yes" date \_\_\_\_\_
- Work Related Yes No
- Illness Yes No If "yes" onset date \_\_\_\_\_

What is your Illness causing your pain? \_\_\_\_\_

How long have you been receiving medical care for your pain/injury? \_\_\_\_\_yrs/months.

Has your medical condition been treated with surgery? Yes No If "yes" answer the following:

Surgery \_\_\_\_\_ Date \_\_\_\_\_

Surgeon \_\_\_\_\_

City and State \_\_\_\_\_

Number of surgeries performed for this medical condition? \_\_\_\_\_

**Specialist Consulted for your current pain problem:** (check all that apply)

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Acupuncture      | <input type="checkbox"/> Pain Clinic     | <input type="checkbox"/> Physical Therapy   | <input type="checkbox"/> Chiropractor    |
| <input type="checkbox"/> Hypnotist        | <input type="checkbox"/> Neurologist     | <input type="checkbox"/> Orthopedic Surgeon | <input type="checkbox"/> General Surgeon |
| <input type="checkbox"/> ENT              | <input type="checkbox"/> Dentist         | <input type="checkbox"/> Podiatrist         | <input type="checkbox"/> Neurosurgeon    |
| <input type="checkbox"/> Spine Specialist | <input type="checkbox"/> Endocrinologist | <input type="checkbox"/> Plastic Surgeon    | <input type="checkbox"/> Rheumatologist  |
| <input type="checkbox"/> Nephrologists    | <input type="checkbox"/> Ophthalmologist | <input type="checkbox"/> Psychologist       | <input type="checkbox"/> Psychiatrist    |

**How has your pain been affecting your life?**

My pain is  always present  sometimes present  only occurs with activity

My pain is  throbbing  burning  stabbing  sharp  aching  
 shooting  crampy  pressure  tiring  dull

My pain  ▲ Increases  ▼ Decreases  ◀ No effect ▶

Sitting	_____	_____	_____
Standing	_____	_____	_____
Walking	_____	_____	_____
Bending	_____	_____	_____
Climbing	_____	_____	_____
Driving	_____	_____	_____
Lifting	_____	_____	_____

I have been to the Emergency Room/Urgent Care within the past 12 months for pain management:

Yes  No

If “yes,” how many times have you been treated in the Emergency Room/Urgent Care for pain management:

1-3 times  4-6 times  More than 6 times

Which ER/UC have you been treated by: (check all that apply)

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> PSL                 | <input type="checkbox"/> Lutheran              | <input type="checkbox"/> St. Joes         | <input type="checkbox"/> Avista              |
| <input type="checkbox"/> Porter              | <input type="checkbox"/> Littleton Adventist   | <input type="checkbox"/> Parker Adventist | <input type="checkbox"/> University Hospital |
| <input type="checkbox"/> VA                  | <input type="checkbox"/> North Suburban        | <input type="checkbox"/> Rose Hospital    | <input type="checkbox"/> SkyRidge Hospital   |
| <input type="checkbox"/> St. Anthony’s North | <input type="checkbox"/> St. Anthony’s Central | <input type="checkbox"/> Denver General   |  |

Other ER: Please list name and location \_\_\_\_\_

Urgent Care: Please list name and location \_\_\_\_\_

**How has your pain been affecting your life (cont'd)?**

I have seen my PCP or specialist for pain management in the last 12 months

- 1-3 times    4-6 times    More than 6 times

Reason for your appointment in clinic?

What concerns do you have regarding your appointment?

What expectations do you have regarding your appointment?

**My pain has been treated in the past with the following:** (check all that apply)

▼ Decreased my pain

▲ Increased my pain

◀ No change to pain ▶

- |   |       |       |       |
|---|-------|-------|-------|
| <input type="checkbox"/> Chiropractor             | _____ | _____ | _____ |
| <input type="checkbox"/> Physical Therapy         | _____ | _____ | _____ |
| <input type="checkbox"/> Occupational Therapy     | _____ | _____ | _____ |
| <input type="checkbox"/> Massage Therapy          | _____ | _____ | _____ |
| <input type="checkbox"/> Pool Therapy             | _____ | _____ | _____ |
| <input type="checkbox"/> Acupuncture              | _____ | _____ | _____ |
| <input type="checkbox"/> Injection Trigger Point  | _____ | _____ | _____ |
| <input type="checkbox"/> Injection ESI            | _____ | _____ | _____ |
| <input type="checkbox"/> Facet Joint Injection    | _____ | _____ | _____ |
| <input type="checkbox"/> Nerve blocks             | _____ | _____ | _____ |
| <input type="checkbox"/> Traction                 | _____ | _____ | _____ |
| <input type="checkbox"/> Spinal Cord Stimulator   | _____ | _____ | _____ |
| <input type="checkbox"/> Biofeedback              | _____ | _____ | _____ |
| <input type="checkbox"/> Heat/Cold Pack           | _____ | _____ | _____ |
| <input type="checkbox"/> TENS                     | _____ | _____ | _____ |
| <input type="checkbox"/> Psychological counseling | _____ | _____ | _____ |

## ***Sleep History***

How many hours on average do you sleep per night? \_\_\_\_\_ hours

How many hours do you sleep during the daytime? \_\_\_\_\_ hours

How many times do you wake at night in pain? \_\_\_\_\_ times

Do you have difficulty falling asleep? Yes No

Do you have difficulty maintaining sleep? Yes No

Have you been told you snore a lot? Yes No

Are you a restless sleeper? Yes No

History of sleep apnea? Yes No

## ***Pain History***

What is causing your current pain? Describe the injury/accident if applicable.

What do you feel has been the most helpful in managing your pain up to this point?

How often are you experiencing moderate or greater pain?

\_\_\_\_\_ Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly \_\_\_\_\_ Yearly

What activities/hobbies have you not been able to perform or accomplish secondary to your pain?

How would you rate your pain on a daily basis?

\_\_\_\_\_ Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe

Is your pain:

\_\_\_\_\_ Intermittent (1-2 hours) \_\_\_\_\_ Most of the day (4-8 hours) \_\_\_\_\_ Chronic (all day)

Does your pain wake you from sleep:

\_\_\_\_\_ Occasionally (1-2/week) \_\_\_\_\_ Frequently (every night) \_\_\_\_\_ Keeps me awake

***Pain History (cont'd)***

When is your pain the worst?

\_\_\_\_ Morning      \_\_\_\_ Afternoon      \_\_\_\_ Evening      \_\_\_\_ Night

What makes your pain:

Better:

Worse:

What studies have been performed regarding your pain?

- |                                |                                       |  |
|--------------------------------|---------------------------------------|--|
| <input type="checkbox"/> MRI   | <input type="checkbox"/> Bone Scan    | <input type="checkbox"/> Lumbar Puncture       |
| <input type="checkbox"/> CT    | <input type="checkbox"/> Upper GI     | <input type="checkbox"/> Biopsy Location _____ |
| <input type="checkbox"/> EMG   | <input type="checkbox"/> Colonoscopy  | <input type="checkbox"/> Joint Aspiration      |
| <input type="checkbox"/> X-RAY | <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Other _____           |

Additional Comments:

**Medications used for your current pain problem:** (check all that apply)

**Narcotic**

	Current	Past	Why Stopped
Hydrocodone (Vicodin)	_____	_____	_____
Oxycodone (Percocet)	_____	_____	_____
Hydromorphone (Dilaudid)	_____	_____	_____
Oxymorphone (Opana)	_____	_____	_____
Morphine (MS Contin, Avinza)	_____	_____	_____
Propoxyphene (Darvon, Darvocet)	_____	_____	_____
Codeine (Tylenol #3)	_____	_____	_____
Methadone	_____	_____	_____
Suboxone	_____	_____	_____
Meperidine (Demerol)	_____	_____	_____
Fentanyl (Duragesic)	_____	_____	_____
Tramadol (Ultram)	_____	_____	_____
Embeda	_____	_____	_____

**Anti-Inflammatory**

Ibuprofen (Advil, Motrin)	_____	_____	_____
Naprosyn (Aleve)	_____	_____	_____
Oxaprozin (DayPro)	_____	_____	_____
Nabumetone (Relafen)	_____	_____	_____
Celecoxib (Celebrex)	_____	_____	_____
Diclofenac (Voltaren)	_____	_____	_____
Acetaminophen (Tylenol)	_____	_____	_____
Salsalate (Disalcid)	_____	_____	_____

**Muscle Relaxants**

Metaxolone (Skelaxin)	_____	_____	_____
Tizandine (Zanaflex)	_____	_____	_____
Methocarbamol (Robaxin)	_____	_____	_____
Carisprodol (Soma)	_____	_____	_____
Baclofen (Lioresal)	_____	_____	_____
Diazepam (Valium)	_____	_____	_____
Clonazepam (Klonopin)	_____	_____	_____
Cyclobenzaprine (Flexeril)	_____	_____	_____

**Neuroleptics**

Gabapentin (Neurontin)	_____	_____	_____
Topiramate (Topamax)	_____	_____	_____
Zonisamide (Zonegram)	_____	_____	_____
Pregabalin (Lyrica)	_____	_____	_____
Carbamazepine (Tegretol)	_____	_____	_____

**Medications used for your current pain problem:** (check all that apply)

**Anti-Depressants**

Fluoxetine (Prozac)	_____	_____	_____
Sertraline (Zoloft)	_____	_____	_____
Citalopram (Celexa)	_____	_____	_____
Paroxetine (Paxil)	_____	_____	_____
Escitalopram (Lexapro)	_____	_____	_____
Venlafaxine (Effexor)	_____	_____	_____
Duloxetine (Cymbalta)	_____	_____	_____
Bupropion (Wellbutrin)	_____	_____	_____

**Sleep Medication**

Temazepam (Restoril)	_____	_____	_____
Zolpidem (Ambien)	_____	_____	_____
Zaleplon (Sonata)	_____	_____	_____
Eszopiclone (Lunesta)	_____	_____	_____
Lorazepam (Ativan)	_____	_____	_____
Trazadone (Deseryl)	_____	_____	_____
Amitriptyline (Elavil)	_____	_____	_____

**Current Medications Prescribed:** (please list dose and how often you take them)

1. _____	2. _____
3. _____	4. _____
5. _____	6. _____
7. _____	8. _____
9. _____	10. _____

**Social History**

Number of Children: \_\_\_\_\_ Children living in home: Yes No Ages: \_\_\_\_\_

Pets: Yes No

Do you smoke? Yes No

If "yes" how many pack per day? \_\_\_\_\_

**Social History (cont'd)**

Do you use caffeinated beverages? (coffee, tea, cola, etc.) Yes No

Do you consider yourself a religious/spiritual person? Yes No

If "yes" answer the following:

Do you attend church/synagogue/spiritual practice?  
Regularly Occasionally On Holidays Never

Do you have a spiritual life that is meaningful/comforting? Yes No

Do you meditate? Yes No

Level of Education: (circle one)

Some High School    High School or GED    Vocational Training  
Some College    College Degree    Advanced Degree

Do you drink alcohol? Yes No

If "yes" answer the following:

How many drinks per day? \_\_\_\_\_

Beer or Hard Liquor? \_\_\_\_\_

Have you been arrested for your drinking or been ticketed for DUI? Yes No

Do you use alcohol for anxiety? Yes No

Do you use alcohol for pain control? Yes No

Have you ever been treated for alcohol abuse/Detox? Yes No

If "yes" answer the following:

Where were you treated? \_\_\_\_\_

Date last treated? \_\_\_\_\_

Do you currently use or have you used illicit/street drugs? Yes No

If "yes" answer the following:

(marijuana, cocaine, heroin, methamphetamine, etc.)

What street drugs have you used in the past? \_\_\_\_\_

What street drugs are you currently using? \_\_\_\_\_

Have you ever been treated for drug abuse? Yes No

If "yes" answer the following:

Where were you treated? \_\_\_\_\_

Date last treated? \_\_\_\_\_

**Social History (cont'd)**

Have you been incarcerated? Yes No  
If "yes" why? \_\_\_\_\_

Have you been involved with domestic violence/abuse? Yes No  
If "yes" answer the following:

I was the victim? Yes No

I was the perpetrator? Yes No

Have you ever been physically/sexually abused? Yes No

Do you currently feel threatened in your environment? Yes No

**Occupational History:**

Are you currently working? Yes No Job Description: \_\_\_\_\_

Are you regular duty at work? Yes No Restricted duty? Yes No

Have you had a previous work related injury? Yes No

If "yes" answer the following:

Are you currently being treated for this work related injury? Yes No

Have you previously had an Impairment Rating? Yes No

Please list the jobs have you had within the past 5 years:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

## Comprehensive Review of Systems

### Constitutional

	Now	Past	Never
Abnormal weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever/chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased exercise tolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Ear/Nose/Throat

Ear infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Allergy/Immunology

Drug Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Neurologic

Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Cardiovascular

Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling in legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of Oxygen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Hematologic/Lymph

Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clotting Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bruising/Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Genitourinary

Discharge (vaginal or penile)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine Retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain with Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful sexual relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Skin

	Now	Past	Never
Skin Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lump/Growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change in color	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Eyes

Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use corrective lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Psychiatric

Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide Thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide Attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Endocrine

Hot flashes (female)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat/Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair/skin changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Gastrointestinal

Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Respiratory

Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Musculoskeletal

Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore Muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### GYN (female only)

Vaginal Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive vaginal itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular menstruation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Past Medical History

Have you had any of the following conditions either now or in the past?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Kidney problems           | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Seizure disorder    | <input type="checkbox"/> Thyroid problems          | <input type="checkbox"/> Arthritis          |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Diabetes           |
| <input type="checkbox"/> Obesity             | <input type="checkbox"/> High cholesterol          | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Periodontal disease | <input type="checkbox"/> Oral gum/bone problem     | <input type="checkbox"/> Cancer             |
| <input type="checkbox"/> Whiplash            | <input type="checkbox"/> Liver disease             | <input type="checkbox"/> Cataracts          |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Manic-depressive disorder | <input type="checkbox"/> TMJ Syndrome       |
| <input type="checkbox"/> Pancreatitis        | <input type="checkbox"/> Alzheimers Disease        | <input type="checkbox"/> Other (list below) |

List any other medical conditions you have had (do not include common cold or flu):

*Illnesses*

*Date(s)*

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List known allergies (including medication allergies):

No known allergies

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**Medical problems/hospitalizations:**

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**Surgical procedures:**

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## Family History

	Mother	Father	Grandparent	Sibling
Headache	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
Stroke	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Rheumatoid	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____
Liver Disease	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Seizure	_____	_____	_____	_____