HEALTH HISTORY FORM

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Phone: (989) 752-1900 Fax: (989) 752-1901

NAME: ______________________________ **DATE:** ______________

AGE: ____________ **DOB:** ______________ **HEIGHT**: __________ **WEIGHT**: ____________

REFERRING PHYSICIAN: __________________ **OTHER PHYSICIANS SEEN FOR THIS PROBLEM:**__________________

PLEASE CHECK THE COORESPONDING BOX IF YOU HAVE EVER HAD ANY OF THE FOLLOWING:

High/Low Blood Pressure		Diabetes		Ulcers	
Heart Disease (heart attack, chest pain)		Hypoglycemia		Reflux	
Heart Murmur		Thyroid Disorder		Colitis	
Irregular Heart Beat (pacemaker, AICD)		Glaucoma		Diverticulitis	
Congestive Heart Failure		Blindness		Bleeding Disorder	
Mitral Valve Prolapse		Kidney Failure/Disease		Hepatitis (Type______)	
Rheumatic Heart Disease		Bladder Problems		Jaundice	
High Cholesterol		Prostate Problems		Sickle Cell	
Deep Vein Thrombosis (blood clot)		Pulmonary Embolism		Blood Disease	
Aneurysm		Asthma		Anemia	
Stroke, TIA		Emphysema		Cancer (Type ____________)	
Blackout Spells		COPD		Depression/Anxiety	
Seizures		Pneumonia		**OTHER:**	
Migraines		Sleep Apnea			
Parkinson's Disease		Home Oxygen			
Rheumatoid Arthritis		Arthritis			
Weakness/Paralysis		Hiatal Hernia		**NONE**	

Is there a possibility that you are pregnant?	Last Menstrual Period:	
Do you/have you smoked?	How much?	Date Quit?
Do you drink alcohol?	How much?	
Do you use recreational drugs?	What kind?	How often?

FAMILY HISTORY:

PLEASE LIST ANY MEDICAL CONDITIONS PRESENT IN:

Mother:
Father:
Siblings:

PREVIOUS SURGERIES/HOSPITALIZATIONS:

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CURRENT MEDICATIONS **-PLEASE LIST *ALL* (PRESCIPTION, OVER THE COUNTER, HERBAL) MEDICATIONS AND DOSAGES**

NAME & DOSAGE:	NAME & DOSAGE:

SEE ADDITIONAL SHEET ☐

DO YOU TAKE ASPIRIN, NAPROSYN/ALEVE/NAPROXEN, IBUPROFEN/ADVIL/MOTRIN, PLAVIX, COUMADIN, WARAFIN OR ANY OTHER BLOOD THINNER? (IF YES, CIRCLE ALL THAT APPLY) HOW OFTEN? ________

ALLERGIES **NONE** ☐

(PLEASE LIST ALL MEDICATION, FOOD, AND OTHER ALLERGIES AND YOUR REACTION)

ALLERGEN:	REACTION:
LATEX ALLERGY? YES / NO	

SEE ADDITIONAL SHEET ☐

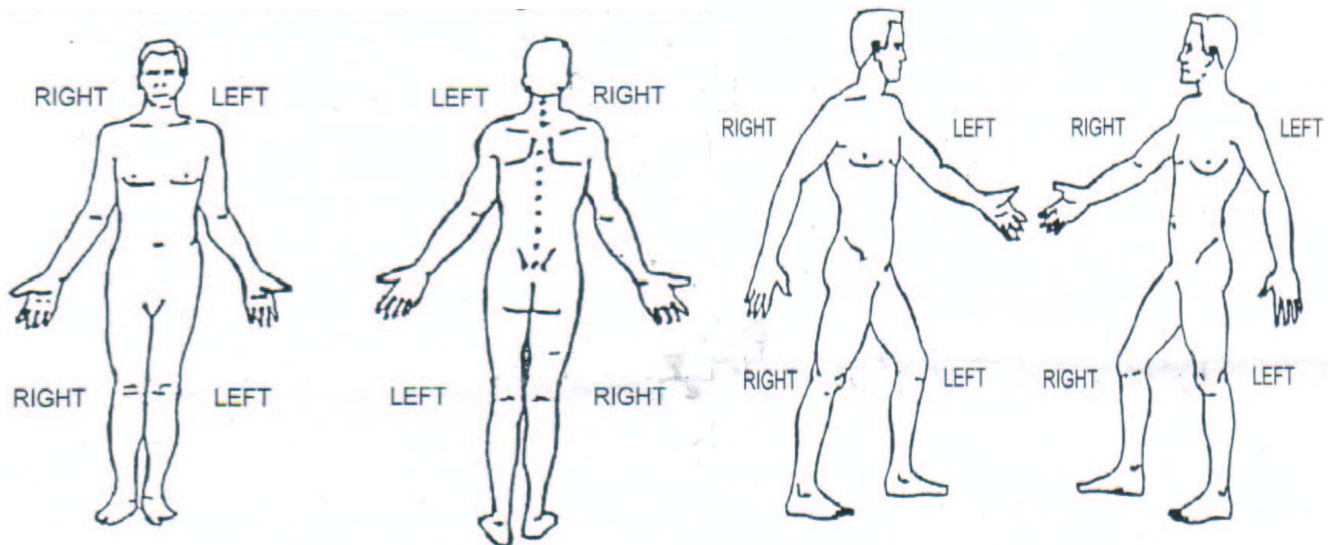
1. CHIEF COMPLAINT: ____

How long have you had this pain? ____

How did the pain begin? ____

On a scale of 1 to 10, how do you rate your pain (with 1 low and 10 high)? ____

2. PLEASE SHADE IN THE AREA ON THE DIAGRAMS WHERE YOUR PAIN IS LOCATED.



3. PLEASE CIRCLE THE APPROPRIATE WORDS THAT BEST DESCRIBE YOUR PAIN.

CONSTANT	BURNING	STABBING	COLDNESS	SHOOTING	UNBEARABLE	DULL
SHARP	HOTNESS	RADIATING	BRIEF	NUMBING	ACHING	CRAMPING
ANNOYING	INTERMITTENT	TINGLING	SEVERE	TRANSIENT	HEAVY	INTENSE

4. PLEASE INDICATE IF THE FOLLOWING INCREASES, DECREASES, OR CAUSES NO CHANGE IN YOUR PAIN.

	Increases Pain	Decreases Pain	NoChange
PHYSICAL ACTIVITY……………	☐	☐	☐
MOVEMENT……………	☐	☐	☐
STANDING……………	☐	☐	☐
WALKING……………	☐	☐	☐
SLEEP. REST……………	☐	☐	☐
LYING DOWN……………	☐	☐	☐
SITTING……………	☐	☐	☐
SNEEZING. COUGHING……………	☐	☐	☐
BOWEL MOVEMENT……………	☐	☐	☐
URINATION……………	☐	☐	☐
SEXUAL INTERCOURSE……………	☐	☐	☐
MASSAGE……………	☐	☐	☐
PRESSURE……………	☐	☐	☐
HEAT……………	☐	☐	☐
COLD……………	☐	☐	☐
DAMP……………	☐	☐	☐
WEATHER CHANGES……………	☐	☐	☐
EATING……………	☐	☐	☐
LOUD NOISES……………	☐	☐	☐
BRIGHT LIGHTS……………	☐	☐	☐

5. Please check any of the following treatments you have had for this pain problem. Include the dates and results.

	TREATMENT	PAIN RELIEF?	IF YES, LENGTH OF RELIEF	DATE
NERVE BLOCKS, EPIDURAL STERIODS……………	Y / N	Y / N	______	______
PHYSICAL THERAPY……………	Y / N	Y / N	______	______
CHIROPRACTOR……………	Y / N	Y / N	______	______
ACUPUNCTURE……………	Y / N	Y / N	______	______

6. Is your pain the result of an…

	YES	NO	If YES, explain and give dates.
ILLNESS……………	☐	☐	______________________
ACCIDENT……………	☐	☐	______________________
WORK RELATED……………	☐	☐	______________________
AUTO RELATED……………	☐	☐	______________________

7. Additional Comments: Please add any comments which you feel would help us in treating your pain.

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8. This signed authorization gives PCMI the ability to obtain, through their electronic system with Sure-scripts, all medication information and prescription benefits that are available on record with the pharmacy program:

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Signature of Patient

9. Pharmacy Information

Pharmacy Name:_______________________ **Pharmacy Phone Number:** ______________

Pharmacy Address: ____

10. Acknowledgement of Notice of Privacy Policies

I ___________________________ acknowledge that I have received the enclosed document from PCMI in regard to their Notice of Privacy Polilcies.

SIGNATURE OF PATIENT ___________________________ DATE ____________________

Notes for Additional Health Information if Needed:

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Thank you very much for taking the time to complete this form.