TO BE COMPLETED BY PATIENT

NAME: _____ **DATE OF BIRTH: _____**

ALLERGIES: _____ **HEIGHT: _____ WEIGHT: _____**

_____

Admissions Health History

HEENT

Hx of Ear Disorders: ____Yes ____No Comment _____

____Tinnitus ____Ear Infection ____Ear Pain

Hx of Eye Disorders: ____Yes ____No Comment _____

____Cataracts ____Glaucoma ____Macular Degeneration

____Eye Infection

Hx of Nasal Disorders: ____Yes ____No Comment _____

____Nose Surgery ____Epistaxis ____Deviated Septum

____Sinusitis

Hx of Throat Disorders: ____Yes ____No Comment _____

____Tonsillitis ____Tonsilletomy ____Adenoidectomy

NEUROLOGICAL

Hx of Neurological Disorders: ____Yes ____No Comment _____

____Cerebrovascular Accident ____Transient Ischemic Attack

____Dementia ____Brain Tumor ____Seizures

____Motor Function Disorder ____Headaches (Including Migraines)

RESPIRATORY

Hx Respiratory Disorders: ____Yes ____No Comment _____

____COPD ____Asthma ____Bronchitis

____Pneumonia ____Tuberculosis ____Pulmonary Embolism

____Tracheostomy ____Sleep Apnea

CARDIO-VASCULAR

Hx of Cardiac Disorders: ____Yes ____No Comment _____

____Heart Attack ____Angina/Chest Pain ____Heart Murmur

____Coronary Artery Disease ____Deep Vein Thrombosis

____Peripheral Vascular Disease ____Cardio-Vascular Surgery

____Cardiac Catherization ____Pacemaker

____Internal Defibrillator ____Hypertension

____Hypotension ____Edema

NAME: _____ DATE OF BIRTH: _____

GASTROINTESTINAL

Hx Gastrointestinal Disorders: ____Yes ____No Comment _____

____Nausea ____Vomiting ____Diarrhea

____Constipation ____Rectal Bleeding ____Gall Bladder Disease

____Pancreatitis ____Ulcer ____Liver Disease

____Gastro Esophageal Reflux ____Abdominal Surgery ____Rectal Surgery

GENITOURINARY

Hx Genitourinary Disorders: ____Yes ____No Comment _____

____Urinary Tract Infection ____Incontinence ____Renal (Kidney) Disease

____Renal Calculi ____Kidney (Renal) Surgery ____Dialysis

____Prostate Problems ____Prostatectomy

REPRODUCTIVE

Hx of Reproductive Disorders: ____Yes ____No Comment _____

____STD'S ____Infertility ____Pelvic Inflammatory Disease

____Endometriosis ____Fibroids ____Gynecologic Surgery

____Menstrual Problems ____Breast Surgery ____Penile Disorders

____Testicular Disorders ____Testicular Surgery

MUSCULOSKELETAL

Hx of Musculoskeletal Disorders: ____Yes ____No Comment _____

____Arthritis ____Degenerative Disc Disease ____Gout

____Fibromyalgia ____Orthopedic Surgery ____Prosthesis

____Back Problems: ____Musculoskeletal Deformity

ENDOCRINE

Hx. Of Endocrine Disorders: ____Yes ____No Comment _____

____Diabetes ____Thyroid Disease

HEMATOLOGICAL

Hx. Of Hematologic Disorders: ____Yes ____No Comment _____

____Anemia ____Leukemia ____Hemophilia

____Sickle Cell Disease ____Clotting Problems ____Bruising

PSYCHO-SOCIAL

Hx. of Psychiatric Disorders: ____Yes ____No Comment _____

____Substance Abuse Disorder ____Bipolar Disorder ____Anxiety

____Depression ____Schizophrenia

NAME: _____ DATE OF BIRTH: _____

ADDITIONAL HEALTH HISTORY

Previous Hospitalization: (previous 5 years) ____Yes ____No Comment_____

_____

____Hx. of Cancer ____Lyme Disease ____Drug Resistant Organisms

____Blood Transfusions ____Blood Transfusion Reaction

____Anesthesia Reaction ____Organ Transplant ____Chemotherapy

____Radiation Therapy ____Alternative Medicine Use ____Recent Travel

____Metal/Implantable Devices

FAMILY MEDICAL HISTORY

____Family Hx Cardiac Disease ____Family Hx. of Cancer ____Family Hx of Diabetes

____Family Hx. of Hypertension ____Family Hx anesthesia Reaction

Family Health History Comment: _____

PAIN HISTORY

History of Pain Prior to Admission: ____Yes ____No

How Long Have You Had Pain: _____

Pain Location: _____

Pain Level: (1-10) _____

Functional Pain Goal: _____

Pain Quality: ___ Burning ___Crushing ___Shooting ___Chronic ____Pounding

(select all that apply) ___Squeezing ___Stabbing ___Sharp ____Dull ____Severe

___ Acute ___Cramping ___Throbbing ___Tingling ____Tightness

___Radiating ___Pressure ___Aching ___Electric like ___Tenderness

___Heaviness ____Numbness ___Labor Pain ___Phantom Pain

Precipitating Factors: ___None ___Minimal Exertion ___Strenuous Exertion

___Trauma ___Eating/Drinking ___Movement

Alleviating Factors: ____Rest ___ Ice ____Heat ____Elevation

(select all that apply) ____Massage ____Position Change ____Medication

____Splinting ____Relaxation Techniques ____Exercise

Pain Present Now: ____Yes ____No