PAST and PRESENT HISTORY, DAILY ACTIVITIES Name:________________________________ Chart # ______________

1. Review of Systems

Do you have a personal history of: o Cancer o Diabetes o Heart Disease o Stroke

Musculoskeletal

Now / Had

- o o Arthritis
- o o Back Problems
- o o Elbow/Wrist Pain
- o o Foot/Ankle Pain
- o o Hip Disorders
- o o Knee Injury
- o o Neck Pain
- o o Osteoporosis
- o o Poor Posture
- o o Scoliosis
- o o Shoulder Problems
- o o TMJ Issues
- o o NONE

Constitutional

Now / Had

- o o Allergies
- o o List:________________
- o o Fainting
- o o Fatigue
- o o Low Libido
- o o Poor Appetite
- o o Sudden Weight Gain
- o o Sudden Weight Loss
- o o Weakness
- o o None

Neurological

Now / Had

- o o Anxiety
- o o Depression
- o o Headache
- o o Dizziness
- o o Pins & Needles
- o o Numbness
- o o None

Cardiovascular

Now / Had

- o o Angina
- o o Bleeding Disorder
- o o Excessive Bruising
- o o High Blood Pressure
- o o High Cholesterol
- o o Low Blood Pressure
- o o Poor Circulation
- o o None

Genitourinary

Now / Had

- o o Excessive Urination
- o o Erectile Dysfunction
- o o Infertility
- o o Kidney Stones
- o o PMS Symptoms
- o o Prostate Issues
- o o None

Digestive

Now / Had

- o o Anorexia/Bulimia
- o o Constipation
- o o Diarrhea
- o o Food Sensitivities
- o o Heartburn
- o o Ulcer
- o o None

Sensory

Now / Had

- o o Blurred Vision
- o o Chronic Ear Infection
- o o Hearing Loss
- o o Loss of Smell
- o o Loss of Taste
- o o Ringing in Ears
- o o None

Endocrine

Now / Had

- o o Frequent Infections
- o o Hypoglycemia
- o o Immune Disorders
- o o Low Energy
- o o Swollen Glands
- o o Thyroid Issues
- o o None

Respiratory

Now / Had

- o o Sleep Apnea
- o o Asthma
- o o Emphysema
- o o Pneumonia
- o o Shortness of Breath
- o o None

Skin

Now / Had

- o o Acne
- o o Eczema
- o o Hair Loss
- o o Psoriasis
- o o Rash
- o o Skin Cancer
- o o None

2. Past, Personal, & Social History

Illnesses

Check any illnesses you **have NOW** or have **HAD** in the past.

Have/Had

- o o AIDS
- o o Alcoholism
- o o Allergies
- o o Cancer
- o o Chicken Pox
- o o Diabetes
- o o Epilepsy
- o o Glaucoma
- o o Gout/Goiter
- o o Heart Disease
- o o Hepatitis
- o o HIV Positive
- o o Measles
- o o Multiple Sclerosis
- o o Mumps
- o o Polio
- o o Rheumatic Fever
- o o Scarlet Fever
- o o STD
- o o Stroke
- o o Tuberculosis
- o o Ulcer
- o o Other: ________

Operations

Surgical interventions which may or may not have included hospitalization.

- o Appendix
- o Bypass Surgery
- o Cancer
- o Cosmetic Surgery:____________
- o Elective Surgery: ____________________
- o Eye Surgery
- o Hysterectomy
- o Pacemaker
- o Spine:____________________
- o Other

Medications You Take

- o High Blood Pressure
- o Anti Anxiety / Depression
- o Blood Thinners
- o Muscle Relaxers
- o Over Counter: Advil, Tylenol, Etc.
- o Other: (List):

Injuries

- o Been in an accident
- o Fractured or broken a bone
  List:
- o Used a crutch or other support
- o Had a spine or nerve disorder
- o Used a neck or back brace
- o Been knocked unconscious

Other

Yes / No

- o o Take time to relax?
- o o Job pressure/stress?
- o o General stress?
- o o Vaccinated?
- o o Mercury fillings?
- o o Recreational drugs?

FEMALES: Pregnant? Yes / No

Due Date:____________________

Ages of Children:________________

Nursing? Yes / No

Birth Control Pills? Yes / No

3. Activities of Daily Living

None-No Effect, **Mild**-Painful(Can do), **Moderate**-Painful(Limited), **Severe**-Can't do

	N	M	M	S
Sitting	o	o	o	o
Rising from chair	o	o	o	o
Standing	o	o	o	o
Walking	o	o	o	o
Lying down	o	o	o	o
Bending over	o	o	o	o
Climbing Stairs	o	o	o	o
Using a computer	o	o	o	o
Get in/out of a car	o	o	o	o
Driving a car	o	o	o	o
Look over shoulder	o	o	o	o
Caring for family	o	o	o	o
Grocery shopping	o	o	o	o
Household chores	o	o	o	o
Lifting objects	o	o	o	o
Reach overhead	o	o	o	o
Shower/bathing	o	o	o	o
Dressing myself	o	o	o	o
Love life	o	o	o	o
Getting to sleep	o	o	o	o
Staying asleep	o	o	o	o
Concentrating	o	o	o	o
Exercising	o	o	o	o
Yard Work	o	o	o	o

4. Family History

	Relative's Health: Good/Poor		Illnesses	Cause of Death: Natural/Illness		Age at Death
Mother	o	o	__________	o	o	_______
Father	o	o	__________	o	o	_______
Sister 1	o	o	__________	o	o	_______
Sister 2	o	o	__________	o	o	_______
Brother 1	o	o	__________	o	o	_______
Brother 2	o	o	__________	o	o	_______

Dr. Notes:

Dr. Initial: Reviewed **o**

Patient Signature: ____ Date: ______________