

Allergies to Medications

Name of Drug	Reaction You Had

Over-the-Counter Medications

Name of Drug	Strength	Frequency Taken

SOCIAL AND OCCUPATIONAL HISTORY

Occupation	
Tobacco	Do you use tobacco? Yes No Current smoker _____ packs per day Past smoker: Quit _____ years ago
Alcohol	Do you drink alcohol? Yes No How many drinks per day _____ per week _____ per month _____
Recreational drugs	Do you use recreational drugs? Yes No
Environmental exposures	Prolonged exposure to toxic environment? Yes No Past work with metals? Yes No

FAMILY HISTORY

Neurological Conditions	
Psychiatric Conditions	
Other	

PAIN REVIEW

Are you currently experiencing any pain? **Yes** **No** If yes, where and for how long?

Circle a number from 1 to 10 that best represents your current pain level.

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
 No Pain A Lot of Pain Worst Imaginable Pain

How would you describe the pain?

- Aching Burning Cramping Dull Heavy Deep
 Itching Numb Pounding Pulling Searing Radiating
 Sharp Shooting Stabbing Stinging Throbbing Tingling

Is pain constant or intermittent? _____

What is the pain relieved by? _____ There is no pain relief

Review of Symptoms

(please check all that apply to you currently or in the recent past)

General symptoms

- Fatigue
- Recent unexplained weight loss or gain
- Change in appetite
- Unexplained fever
- Disturbance of sleep pattern

Eyes/Ears/Nose/Mouth

- Decreased, blurred or double vision
- Excessively dry eyes
- Episodes of eye inflammation
- Ringing in ears
- Dizziness/vertigo
- Frequent sinus infections
- Excessively dry mouth
- Recurrent lip or mouth ulcers
- Difficulty swallowing
- Hoarseness/change in voice

Heart and Circulation

- High blood pressure
- Racing heart rate, irregular heart rhythm
- History of heart attack or exertional chest pain
- Blood clots in arms, legs or lungs

Stomach

- Chronic constipation
- Chronic diarrhea
- Nausea and/or vomiting
- Loss of bowel control

Lungs

- Chronic cough
- Shortness of breath

Kidneys/Bladder

- Difficulty urinating
- Loss of bladder control
- History of kidney stones

Muscles and Bones

- Muscle pain or cramps
- Joint pains

Skin

- Unexplained rashes
- Sun-sensitive or ill-feeling after sun exposure

Hormone-endocrine

- Underactive or overactive thyroid gland
- Other hormonal disorders
- Miscarriages

Blood

- History of anemia
- Vitamin B12 deficiency
- History of blood clots
- History of miscarriage

Psychological

- Depression
- Anxiety
- Seen a psychiatrist or psychologist