Patient: ______________________ Height: ________ Weight: ________
Date: ______________________

HISTORY:

Reason for visit: ______________________
Location of problem: ______________________
When did the problem start? ______________________
How severe is the problem? ______________________
How often do you experience this problem? ______________________
Does anything make this problem better or worse? ______________________
Any other signs/symptoms? (ex: drainage,redness,swelling) ______________________

____

MEDICAL HISTORY:

*Patient medical history

Diabetes	No	Yes
Hypertension	No	Yes
Cancer	No	Yes
If yes, location	______	
Stroke	No	Yes
Heart trouble	No	Yes
Arthritis/gout	No	Yes
Convulsions	No	Yes
Bleeding tendency	No	Yes
Acute infections	No	Yes
Venereal disease	No	Yes
Hereditary disease	No	Yes

Previous hospitalizations/surgeries/serious injuries:

____

Medications: ______________________

*Patient social history

Marital status ______
Use of alcohol: Never Rarely Moderate Daily
Use of drugs: Never Type/frequency: ______________________
Excessive exposure at home or work to: Fumes Dust Solvents Airborne particles

*Family medical history

	Age:	Diseases:	If deceased, cause of death:
Father			
Mother			
Siblings			
Children			