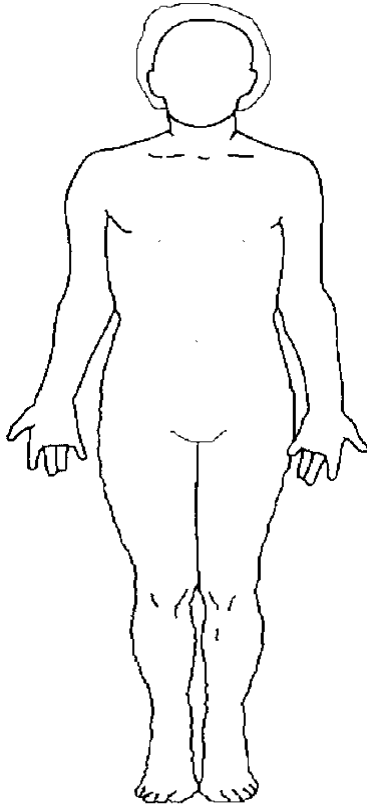


Name: _____ age: _____ date: _____

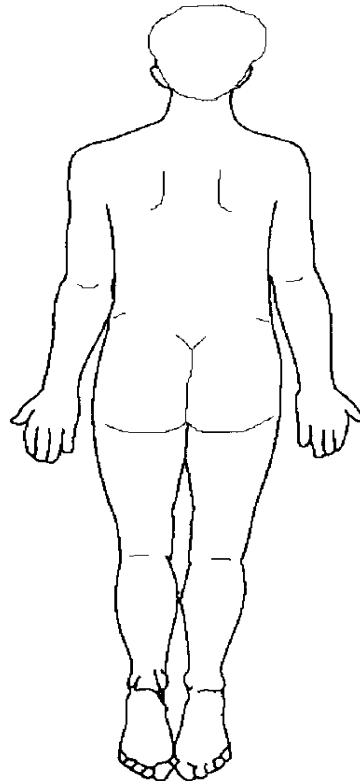
PAIN DIAGRAM. Mark the areas on your body where you now feel your typical pain. Include all areas. Use the following symbols below. (If you have no pain skip to next page.)

Pain XXXXXX Numbness OOOOOO Pins and needles ///////////////
 XXXXXX OOOOOO ///////////////

Put a large **X** over the spot that you have the most pain.



FRONT SIDE



BACK SIDE

How often do you have your pain?

___constant ___comes and goes ___daily ___weekly ___monthly

How would you describe your pain?

___throbbing ___dull ___hot-burning ___tender ___sickening
___shooting ___cramping ___aching ___splitting ___fearful
___stabbing ___gnawing ___heavy ___tiring ___punishing
___sharp

How severe is your pain at worst? (0-10; 0=no pain, 10=worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

How severe is your pain at best?

0 1 2 3 4 5 6 7 8 9 10

What makes the pain worse?

What makes the pain better?

REVIEW OF SYSTEMS. Mark any of the following symptoms that you have had during the past year.

CONSTITUTIONAL SYMPTOMS

- Recent weight change
- Fever or chills
- Night sweats
- Lack of energy or fatigue
- none of the above

EYES

- Eye pain or redness
- Loss of vision
- Blurred vision or double vision
- none of the above

EARS/NOSE/MOUTH/THROAT

- Hearing loss
- Ringing in ears
- Nose bleeds
- Difficulty swallowing
- Hoarseness
- none of the above

CARDIOVASCULAR

- Chest pain
- Abnormal heartbeat
- Shortness of breath with activity
- Shortness of breath when lying flat
- Swelling of feet or ankles
- none of the above

RESPIRATORY

- Chronic or frequent coughs
- Coughing up blood
- Breathing problems
- none of the above

GENITOURINARY

- Bloody urine
- Urgency of urination
- Frequency of urination
- Painful or difficult urination
- Dribbling or incontinence of urine
- Numbness over groin, genitalia or buttocks
- Sexual difficulties
- none of the above

MUSCULOSKELETAL

- Joint pain, stiffness, or swelling
- Muscle pain or cramps
- Increased pain with laying flat
- none of the above

SKIN/BREAST

- Rash
- Skin sores or ulcers
- Breast pain, lump or discharge
- none of the above

STOMACH AND INTESTINES

- Frequent nausea or vomiting
- Bloody vomiting
- Abdominal pain
- Recurring diarrhea
- Blood in stools
- Frequent or severe constipation
- none of the above

NEUROLOGICAL

- Headaches
- Light headedness or dizziness
- Convulsions or seizures
- Numbness or tingling in arms or legs
- Weakness in arms or legs
- Frequent falls
- none of the above

PSYCHIATRIC

- Difficulty sleeping
- Loss of appetite
- Memory loss or confusion
- Nervousness or anxiety
- Stress
- Depression
- none of the above

ENDOCRINE

- Easy bleeding or bruising
- Swollen glands or lumps in neck, armpits or groin
- none of the above

ALLERGIC/IMMUNOLOGIC

- History of allergic reaction to:
- Penicillin or other antibiotics
 - Morphine, Demerol, or other narcotics
 - Vaccines or anesthetics
 - none of the above

OTHER (please list any other symptoms)

PAST MEDICAL HISTORY. Mark any condition that you have had.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Drug or alcohol addiction | <input type="checkbox"/> Stomach/duodenal ulcer |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gallbladder disease |
| <input type="checkbox"/> Abnormal heart rhythm | <input type="checkbox"/> Seizures | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Head injury | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke or TIA | <input type="checkbox"/> Broken bones | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Depression | <input type="checkbox"/> Arthritis or Gout | <input type="checkbox"/> HIV infection |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> none of the above |

Please list any other illnesses, hospitalizations, injuries, or operations.

ALLERGIES. List all allergies to medications.

MEDICATIONS. List your current medications with dosages.

CURRENT MEDICAL ISSUES. List any other current medical problems.

FAMILY MEDICAL HISTORY. List any illnesses that run in the family.

(example: diabetes, cancer, stroke, heart problems, muscle problems, nerve problems, depression, alcoholism, etc.)