1. Have you had or, or do you have, any of the following illnesses or diseases? Please circle.

Cancer	High Blood Pressure	Gallstones	Convulsion
Phlebitis / Leg Clot	Heart Attack	Jaundice	Concussion
Pulmonary Embolus (Lung Clot)	Heart Failure	Liver Cirrhosis	Depression
Blood Transfusions	Heart Murmur	Bowel Obstruction	Anxiety
Anemia	Rheumatic Fever	Hepatitis	Migraine / Tension Headaches
Excessive Bleeding	Emphysema	Ulcer	Stroke
Poor Blood Flow	Tuberculosis	Hernia	Nerve Disease
Thyroid Disease	Asthma	Urinary Infection	Post-Traumatic Stress Syndrome
Cataracts	Bronchitis	Kidney Disease	Other _____
Glaucoma	Sinus Disease	Kidney Stones	_____

2. Do you take any medications, supplements or injections that you take on a regular basis? NO YES Please list.

_____

_____

_____

_____

3. Do you have any allergies? NO YES Please list drug and reaction.

_____

_____

4. Have you ever had any surgery or operations of any kind? NO YES Please list.

Date	Type	Hospital	Surgeon	Complications

5. Have you had any fractures, sprains, arthritis symptoms or other orthopaedic conditions? NO YES Please list.

Date	Type	Mechanism of Injury	Complications

6. Please indicate your approximate use or intake of the following:

	Type	Per Day	Per Week	Previous Use
Caffeine				
Nicotine				
Alcohol				
Drugs				

7. What is your occupation? _____

8. Do you have a lawyer involved in this case? _____
   If so, what is his/her name? _____

_____ _____

NAME **DATE**

9. Are you: Single Married Widowed Divorced

10. Any children? NO YES If so, list age and sex of each.

_____

_____

11. When did the current injury or pain start? _____

12. Please describe factors that improve or lessen your pain or symptoms.

_____

13. Please describe factors that worsen or aggravate your pain or symptoms.

_____

14. Do you have any of the following symptoms or complaints? IF SO, PLEASE CIRCLE

EYES & VISION	**EARS & HEARING**	**NOSE & THROAT**
Loss or change of vision	Loss of hearing	Hoarseness
Eye pain or redness	Buzzing or noises in ear	Blocked nasal passages
Excessive watering	Ear infection / drainage	Nosebleeds
Double vision	Other_____	Frequent running nose
Other_____		Difficulty swallowing
		Other_____
RESPIRATORY	**CARDIOVASCULAR**	**GASTROINTESTINAL**
Wheezing	Chest pain	Digestion difficulties
Bloody sputum	Abnormal or fast heartbeat	Frequent nausea or vomiting
Excessive cough	Calf cramps w / walking	Lack or loss of appetite
Night sweats	Varicose veins	Stomach or abdominal pain
Shortness of breath	Cold sensitivity of toes & fingers	Freq loose bowel or recurring diarrhea
Other_____	Frequent or marked swelling of ankles & feet	Bloody stool, Black stool
		Frequent or severe constipation
	Other_____	Other_____
GENITOURINARY	**GENITOURINARY (MALE)**	**GENITOURINARY (FEMALE)**
Urinary Incontinence	Penile pain	Breast discharge, swelling, lumps
Bloody urine	Abnormality of testicles	Vaginal pain
Painful urination	Scrotal swelling	Known uterine fibroids / tumors
Flank pain	Infection or sores	Infections
Urination urgency	Prostatitis	Abnormal or painful menstrual flow
Difficulty starting or passing urine	Penile discharge	Infertility or difficulty conceiving
	Difficulty in sexual function	Change in body hair distribution
Other_____	Other_____	Difficulty in sexual function
		Other_____

EMOTIONAL/PSYCHOLOGICAL		**NEUROLOGICAL**
Insomnia	Frequent nightmares	Severe or frequent headaches
Depression	Hysterical attacks	Unusual head or neck tension
Recurrent feeling of loneliness/hopelessness	Constant unhappiness	Dizziness
	Other_____	Fainting spells
Excessive worry		Severe lapses of memory
Severe tension		Shaking or twitching spells
Feeling of worthlessness		Paralysis of limbs
Nervous tension		Blackouts
Frequent crying		Other_____

_____ _____

NAME **DATE**