HISTORY & REVIEW OF SYSTEMS
Shiloh and Primary Care

PATIENT NAME: _____ **DOB:** _____

******Is today's visit related to a work compensation injury or auto/personal injury: (circle) YES / NO******

HEENT: □ Head Trauma/Concussion □ Glasses/Contacts (circle) □ Glaucoma □ Cataracts
□ Hearing Aids-left/right/bilateral (circle) □ Dentures/Crowns □ Blindness-left/right/bilateral (circle)

PULMONARY: □ Asthma □ Emphysema □ Pneumonia □ Bronchitis
□ COPD-BIPAP/CPAP/Inhalers/NO PAP (circle) □ Sleep Apnea-BIPAP/CPAP/NO PAP (circle)

CARDIOVASCULAR/VASCULAR: □ High Blood Pressure □ Heart Disease □ High Cholesterol
□ A-Fib □ Aneurysm □ Blood Clot/DVT □ Heart Attack □ Open Heart Surgery
□ Stents □ Pacemaker/Defibrillator (circle) □ Vascular Disease □ Varicose Veins

ENDOCRINOLOGY: □ Diabetes-Type I/Type II (circle) □ Thyroidism-Hypo/Hyper (circle)
□ Kidney Disease □ Liver Disease

GASTROINTESTINAL: □ Heartburn/Acid Reflux (circle) □ Constipation
□ Crohn's/Ulcerative Colitis (circle)

HEME/LYMPH: □ Anemia □ Clotting/Bleeding disorders □ Cancer-type_____
□ HIV/AIDS (circle) □ Hepatitis-A/B/C (circle)

DERMATOLOGICAL: □ Acne/Rosacea (circle) □ Eczema/Psoriasis (circle) □ Hair Loss/Alopecia
□ Skin Cancer-Personal/Family (circle) Location if Personal History:_____
_____

NEUROLOGICAL: □ Numbness/Tingling-where_____
_____□ Headaches/Migraines (circle) □ Epilepsy □ Seizures
□ Stroke □ TIA □ Insomnia □ Multiple Sclerosis □ Dementia □ Alzheimer's
□ Parkinson's □ Tremors □ Sciatica □ Fibromyalgia □ Lyme's Disease □ Restless Leg Syndrome

MUSCULOSKELETAL: □ Joint Pain-where_____

□ Back Pain-Upper/Middle/Lower (circle) □ Difficulty Walking-cane/walker/wheel chair (circle)
□ Arthritis-Type_____ □ Artificial Joints-where_____

PSYCHIATRIC: □ Depression □ Anxiety □ PTSD □ ADHD/ADD (circle) □ Bipolar

ANY OTHER HEALTH ISSUES:_____
_____
_____

SURGERIES (INCLUDE YEAR):_____
_____
_____
_____

(CONTINUED ON BACK SIDE)

HISTORY & REVIEW OF SYSTEMS
Red Lion Pain and Primary Care
(Continued)

MEDICATION ALLERGIES: _____

CURRENT MEDICATIONS:

	Name	Dose/Strength	How often per day
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

TOBACCO
□ Current Smoker-How much_____
□ Former Smoker-QUIT_____
□ Never Smoker

ALCOHOL
□ Do Not Drink
□ Drink Daily-How much_____
□ Frequent Drink-How much_____
□ Occasionally Drink-How much_____
□ History of Alcoholism-QUIT_____

DRUG ABUSE
□ IVDU-Last Use_____
□ Illicit Drug Use_____
□ No Illicit Drug Use

CARDIOVASCULAR
□ Eat healthy meals
□ Regular exercise
□ Take daily aspirin

SAFETY
□ Household Smoke Detector
□ Keep firearms in house
□ Wear seat belt

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CONTROL SUBSTANCE PATIENTS - What prior treatments have you used to treat the symptoms:

TREATMENTS	TYPE OF RELIEF			
□ Activity Modification	None	Moderate	Excellent	
□ Brace	None	Moderate	Excellent	What type brace: _____
□ TENS Unit	None	Moderate	Excellent	
□ Heat Treatment	None	Moderate	Excellent	
□ Ice Treatment	None	Moderate	Excellent	
□ Weight Reduction	None	Moderate	Excellent	
□ Injections	None	Moderate	Excellent	What type of injections: _____
□ Chiropractic	None	Moderate	Excellent	
□ Physical Therapy	None	Moderate	Excellent	
□ Massage	None	Moderate	Excellent	
□ Acupuncture	None	Moderate	Excellent	
□ Surgery	None	Moderate	Excellent	

Medications tried: _____

Patient Signature: _____ **Date:** _____