New Patient
Medical Data Form

Patient's Name: _____ Today's Date _____

Age: _____ Date of Birth: _____

Referred by: _____
(Primary Care Physician)

_____
(Family Doctor)

_____
(Attorney) (Chircpractor) (Friend) (Other)

1. What is your main problem for today's visit?

   _____

   _____

2. Do you have a history of:

   ☐ Diabetes ☐ Heart Problems ☐ Thyroid Problems

   ☐ High Blood Pressure ☐ Seizures (Epilepsy) ☐ Other _____

   ☐ Stroke ☐ Cancer

3. Please list previous surgeries or hospitalizations

   Surgery / Hospitalizations?

   Date: _____ Reason: _____

   Date: Reason: _____

   Date: Reason: _____

4. Please list medications you are currently on:

   _____ _____

   _____

   _____ _____

   _____ _____

5. Please list medications you have had an adverse or allergic reaction to:

   _____ _____

   _____ _____

   _____

   _____ _____

6. Please list over-the-counter medications that you take regularly or occasionally:

   _____ _____

   _____ _____

   _____ _____ _____

7. (a) Do you take aspirin regularly (daily)? ☐ Yes ☐ No

   (b) Do you drink alcohol? ☐ Yes ☐ No

   (c) Do you smoke? ☐ Yes ☐ No

8. What Medical illnesses (if any) tend to run in your immediate family?

Mother		Father		Brother		Sister	
☐ Stroke	☐ Seizures	☐ Stroke	☐ Seizures	☐ Stroke	☐ Seizures	☐ Stroke	☐ Seizures
☐ Heart Disease	☐ Other	☐ Heart Disease	☐ Other	☐ Heart Disease	☐ Other	☐ Heart Disease	☐ Other

Notes: _____

_____

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REVIEW OF SYSTEMS

Patient Name_____Date of Birth_____

Please place a checkmark in front of any of the following items which the patient is experiencing at the present time.

1. "Constitutional":	fever	____weight loss	____fatigue
2. "Eye Problems":	blurred vision	____double vision	loss of vision
	____eye pain	____eye redness	____eye dryness
3. "Ear/nose/throat":	____trouble hearing	____ringing in ear	____dizziness (vertigo)
	loss of balance	____ear pain	____ear discharge
	hoarseness	____trouble swallowing	____slurred speech
4. "Cardiovascular":	____chest pain	____irregular heart beat	fast heart beat
	____limb swelling	____limb pain on walking	____fainting
5. "Respiratory":	____trouble breathing	____chronic cough	____coughing blood
6. "Gastrointestinal":	____indigestion	____heart burn	____abdominal pain
	nausea	____vomiting	____regurgitation
	diarrhea	____constipation	____bloody stools
7. "Genitourinary":	incontinence	____pain on urination	blood in urine
8. "Musculoskeletal":	____muscle pain	____muscle cramp	muscle twitches
	loss of muscle bulk	____neck pain	____back pain
	____joint pain	____joint stiffness	____joint swelling
9. "Skin":	numbness	____tingling	discoloration
	hair loss	____nail changes	____sweating changes
10. "Neurologic":	headache	____face pain	____face numbness
	weakness	____tremors	clumsiness
	blackouts	____trouble with memory	____trouble concentrating
11. "Psychiatric":	____depression	____anxiety	____mood swings
12. "Hematologic/ lymphatic":	____abnormal bleeding	____pain on urination	blood in urine
13. "Allergic/ immunologic":	skin rash	____joint pain	____dry eyes &/or dry mouth
14. "Endocrine":	excessive thirst	____heat/cold intolerance	excessive urination

Signature of person completing this questionnaire: _____

Relationship to Patient_____

The above information – Past Medical History, Family History, Social History, and Review of Systems – may be obtained as a questionnaire completed by the patient, relatives or ancillary staff provided that it is signed and dated by the treating physician.

Physician Signature: Date:

Headache Patient
Data Form

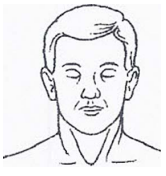
Patient's Name: _____ Today's Date_____

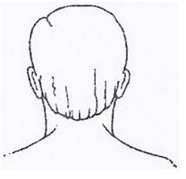
Age: _____ Referred by:_____
(Primary Care Physician)

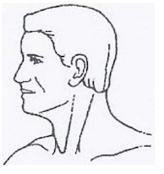
_____
(Family Doctor)

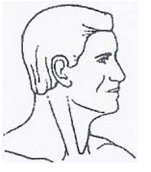
_____
(Attorney) (Chiropractor) (Friend) (Other)

1. How long have you been having headaches?
   Number of months Number of years _____
2. When do you think the headaches began? _____
   (Date)
3. Are your headaches episodic ☐ or daily ☐?
4. How long do they usually last?
   ☐ A few minutes ☐ Several hours ☐ All day
5. Where are your headaches located (Please indicate or describe)


Front


Back


Left Side


Right Side

6. Do you get sick to your stomach or vomit with your headaches? ☐ Yes ☐ No
7. Do headaches cause you to take much time off from your normal activities or work?
   ☐ Yes ☐ No
8. What vision problems, if any, do you have with your headaches?
   ☐ Blurry Vision ☐ Spots ☐ Zig Zag Lines ☐ Other _____
9. Have you ever had any serious head trauma?
   ☐ Yes ☐ No
10. What tests, if any, have been performed to help investigate your headaches?
    ☐ CT Scan ☐ MRI Scan ☐ EEG ☐ Other
11. What prescription medications or over the counter medications, have you tried for your headaches?

    _____ _____ _____

    _____ _____ _____

    _____ _____ _____
12. Who in your family also has a history of headaches?
    ☐ Mother ☐ Father ☐ Other

Notes: _____

_____

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_____