

# Interval History

Date: \_\_\_\_\_  
What is your name: \_\_\_\_\_  
Date of last visit: \_\_\_\_\_  
Referring physician: \_\_\_\_\_  
Primary care physician: \_\_\_\_\_  
Are you Right: \_\_\_\_\_ or Left: \_\_\_\_\_ Handed?  
DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Please describe what new current problems you are having:

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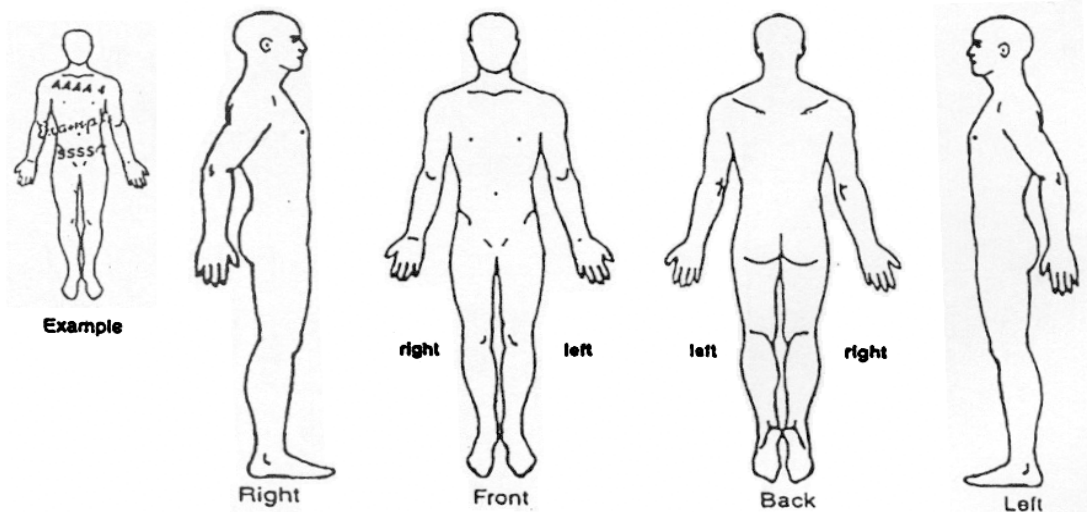
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## SHOW US WHERE YOUR DISCOMFORT IS

Please mark area(s) of injury or discomfort using the appropriate symbols, as shown in the example below.  
Please include all affected areas. Please circle any areas of pain not represented by a symbol.  
**ACHING: AAA BURNING: BBB STABBING: SSS NUMBNESS: NNN PINS & NEEDLES: PPP**



## NOTES

# YOUR PAST HEALTH HISTORY

Do you currently have any of the following diseases/medical conditions?:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Appetite decrease               | <input type="checkbox"/> Fatigue (excessive)        | <input type="checkbox"/> Sleeping difficulty                   |
| <input type="checkbox"/> Artificial bones/joints _____   | <input type="checkbox"/> Fevers (unexplained)       | <input type="checkbox"/> Stiffness in the AM                   |
| <input type="checkbox"/> Bleeding Tendency               | <input type="checkbox"/> Headaches, severe/frequent | <input type="checkbox"/> Stomach problems/pain                 |
| <input type="checkbox"/> Blood in stools                 | <input type="checkbox"/> Hearing Loss               | <input type="checkbox"/> Stress at home/work                   |
| <input type="checkbox"/> Bowel habit changes             | <input type="checkbox"/> Joint pain and/or swelling | <input type="checkbox"/> Swollen ankles                        |
| <input type="checkbox"/> Bowel incontinence              | <input type="checkbox"/> Kidney problems            | <input type="checkbox"/> Urinary difficulty                    |
| <input type="checkbox"/> Breathing difficulty lying flat | <input type="checkbox"/> Lower back pain/problems   | <input type="checkbox"/> Urinary incontinence                  |
| <input type="checkbox"/> Breathing difficulty            | <input type="checkbox"/> Muscle tenderness          | <input type="checkbox"/> Urinating frequently at night         |
| <input type="checkbox"/> Bruise easily                   | <input type="checkbox"/> Neck pain (frequent)       | <input type="checkbox"/> Visual disturbance or change          |
| <input type="checkbox"/> Chest pain or tightness         | <input type="checkbox"/> Night sweats               | <input type="checkbox"/> Weakness of arms or legs (circle)     |
| <input type="checkbox"/> Cough, persistent or unusual    | <input type="checkbox"/> Paralysis                  | <input type="checkbox"/> Weight loss of >10 lbs. (intentional) |
| <input type="checkbox"/> Dizziness                       | <input type="checkbox"/> Sinus problems             | <input type="checkbox"/> Other _____                           |
| <input type="checkbox"/> Dry eyes, mouth or throat       | <input type="checkbox"/> Skin rashes                |  |

**For female patients only:** Do any of the following apply to you?

- |   |  |
|---|--|
| <input type="checkbox"/> Currently pregnant                                     | <input type="checkbox"/> Taking birth control pills        |
| <input type="checkbox"/> Disorders of the breast                                | <input type="checkbox"/> Currently in menopause            |
| <input type="checkbox"/> Perform monthly self-breast exam                       | <input type="checkbox"/> Pap smear within the last 2 years |
| <input type="checkbox"/> Mammogram within the last 2 years                      | <input type="checkbox"/> Take over 1000mg of calcium daily |
| <input type="checkbox"/> Vaginal bleeding other than at the time of your period |  |

## HOSPITALIZATION HISTORY SINCE YOUR LAST VISIT

**PLEASE LIST PREVIOUS HOSPITALIZATIONS/ SURGERIES:**

DATE	TYPE OF SURGERY	PHYSICIAN/SURGEON	PLACE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

# MEDICATIONS THAT YOU HAVE CHANGED SINCE YOUR LAST VISIT

Please list all of the medications (prescriptions and non-prescriptions) that you now take:

NAME OF MEDICATION	DOSAGE	PRESCRIBED BY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## ALLERGIES

Please list anything that you may be allergic to (medications, tape, food, etc.): \_\_\_\_\_

\_\_\_\_\_

## SOCIAL HISTORY

What kind of work do you do? \_\_\_\_\_ Employer: \_\_\_\_\_

Are you on disability? \_\_\_ Yes or \_\_\_ No If yes, since what date? \_\_\_\_\_

What is your marital status? *Married Single Divorced Separated Widowed*

Number of children? \_\_\_\_\_ Ages? \_\_\_\_\_

Hobbies and Recreational Activities? \_\_\_\_\_

Do you smoke? *Now/Past* What substance? \_\_\_\_\_ How many per day? \_\_\_\_\_ How long? \_\_\_\_\_

Do you drink alcohol? *Now/Past* What kind? \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_

Do you use recreational drugs? *Now/Past* What kind? \_\_\_\_\_ How long? \_\_\_\_\_

**Please sign and date this form as being true and correct:**

\_\_\_\_\_ Patient

\_\_\_\_\_ Date

\_\_\_\_\_ Patient's Representative

\_\_\_\_\_ Date

DIAGNOSIS: \_\_\_\_\_

PLAN: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_