David M. McKalip, M.D., LLC .
Patient History

Name: _____ Date: _____ Age _____

Date of Birth: _____ Biological Sex: Male____ Female____ | Right ____or Left ___Handed

Chief Complaint - problem(s) for which you are here today:

_____

_____

_____

_____

Location: _____
Where is the problem/pain?

Severity: _____ Duration: _____
How severe is the problem? When did it start?

Timing: _____ Context: _____
Does problem/pain occur at a specific time? Where were you when it started?

Associated symptoms: _____
Numbness, tingling, weakness, visual changes, etc. - Where on body?

Modifying Factors: _____
What, if anything, makes problem/pain better or worse?

Have you ever had same problem before? _____

If yes, when/where: _____

Have you seen other doctors or had surgery for this problem before?

(please indicate doctor and date)

Doctor	Approximate Date

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Past Medical History: Please indicate if you have or have had any of the following illnesses:

Heart Disease	Lung Disease	Cancer	Other
__Heart Attack __Angina __Rheumatic Fever __Valve disease __Irregular heart beat __High Blood Pressure	__Emphysema __Pneumonia __Asthma __Bronchitis	__Breast __Prostate __Lung __Skin Other_____	__Diabetes __Kidney Disease __Skin Disease __Liver disease (Hepatitis, cirrhosis etc…) __Sexually transmitted Disease __Psychiatric diagnosis (bipolar disorder, schizophrenia, depression etc….)

Please list any other medical problems or relevant details of above:

_____
_____
_____
_____

Surgical History: Please list any prior surgeries, along with dates, surgeon, city and hospital if available.

Operation	Date/Surgeon/City/Hospital

Prescriptions:

Medication	Strength (dose)	Amount / Frequency

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Non-prescription remedies/medications you take regularly:

_____

_____

_____

Allergies:_____

_____

_____

Social History:

Town/location of Permanent Residence: _____ ___Seasonal Resident
Occupation:_____ __Retired
Company:_____
Primary Care Doctor_____
Employed now? __Y __N __on sick/disabled leave. Approximate date ceased employment_____
Work related Injury ___Y ___N Approximate Date of Injury:_____
Pain onset related to an injury? __Y___N Approximate Date:_____
Workman's compensation case? ___Y____N
Legal case pending relating to your illness/injury?__Y___N. Attorney:_____
Applying for ___or receiving ____disability income related to this injury/illness? ___Y ____N

Substance	**Daily amount**	**Number of years**	**Marital Status:** Single ____ Married ____ Widowed ____ Separated ____ Divorced ____ **Number of Children:** ____
___Tobacco			
___Alcohol			
___Recreational Drugs (list please)			

Family History: Please list any medical conditions or illness that are present in your family.

Other/Details of items indicated above:

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Review of Systems: Please indicate if you currently or regulary are experiencing any of the following if not already described. (Check if "yes", otherwise will assume "no"):

Constitutional __General Good Health Lately __Fever __Weight Loss __Weight Gain **Hematologic** __Bleeding Gums __Easy Bruising __Tendency to bleed easily **Pulmonary/Cardiac** __Chest Pain __Irregular heart beat __New or persistent cough __Productive cough __Bloody cough __Wheezing __Shortness of breath **Endocrine** __Excessive Thirst __Excessive Urination **Musculoskeletal** __Joint Pain __Muscle wasting	**Ears/Nose/Throat** __Nasal discharge or postnasal drip __Nasal bleeding __Bleeding gums __Tooth infections **Skin** __New moles/skin abnormalities __Rash __Open sores __Skin Growth **Gastrointestinal/ Genitourinary** __Stomach/Abdominal Pain __ Indigestion __Diarrhea __Constipation __Blood in stool __Blood in urine __Foul Smelling urine __Rising from sleep to urinate **Psychiatry/Other** __Hallucinations __Depression __Hearing Voices __Anxiety __Claustrophobia	**Neurologic** __Loss of speech/poor speech/poor understanding of speech __Confusion __Poor memory __Headache __Change or loss of smell/taste __Loss of vision/poor vision __L__R __Double vision __Blind spots __L__R __Visual flashing __L__R __Facial pain/numbness or weakness __L__R __Loss of hearing/poor hearing __L__R __Ringing in ears __L__R __Difficulty swallowing __Arm Pain/numbness/tingling __L__R __Leg Pain or numbness __L__R __Neck Pain __Back Pain __Other Pain or numbness __Arm Weakness __L__R __Leg Weakness __L__R __Loss of Bladder or Bowel control __Poor Sexual function __Difficulty Walking __Loss of coordination

Other/Details of items indicated above:
