James Kayvanfar, M.D.

Patient Medical History

Today's Date:___/___/_____

Full Name (Last, First MI):_____ **Occupation:**_____

Dominant hand: ☐**Right** ☐**Left** **Height:**_____ft _____in **Weight:**_____lbs **Age**:_____yrs

Current complaints (why are you seeing the doctor?) - indicate location and severity of pain/symptoms:_____

_____

_____

_____ **When did this problem start?** ___/___/___

How long you have had the current pain or symptom? _____days _____weeks _____months _____years

How did your problem first start or the injury first occur? _____

_____

Is your current pain/symptoms: ☐Sharp/Stabbing ☐Dull ☐Aching ☐Burning ☐Numbness ☐Pins & Needles

What makes the pain/symptoms worse? ☐Sitting more than_____(e.g 1 hour) ☐Standing more than_____

☐Walking more than_____ ☐Walking uphill ☐Walking downhill ☐Bending forward ☐Bending backward

☐Lying down ☐Lifting/carrying more than_____ ☐Overhead reaching/working ☐Coughing ☐Sneezing

☐After these activities:_____ ☐During these activities:_____ ☐Nothing

What makes the pain/symptoms better? ☐Lying down ☐Sitting ☐Standing ☐Walking ☐Physical therapy

☐Exercises ☐Manipulation ☐Pain medications ☐Muscle relaxants ☐Aspirin or anti-inflammatory pills

☐Epidural steroid injections ☐Cortisone injections ☐Traction ☐Other:_____ ☐Nothing

Have you previously seen any doctors for this problem? ☐No ☐Yes: How many:_____ Dates & Locations:_____

_____

_____

Have you been hospitalized for this problem? ☐No ☐Yes: Number of time:_____ Dates & Locations:_____

_____

Have you had surgery for this problem? ☐No ☐Yes: Number of time:_____ Dates & Name of the Procedure:_____

_____

_____

Check all of the tests which you have had for this problem: ☐1. Diagnostic X-rays ☐2. MRI ☐3. CT scan

☐4. Myelogram ☐5. Discogram ☐6. EMG or Nerve Study ☐7. Other:_____

Please write the **Date, Body Location & Result** of each test:_____

_____

_____

Please turn sheet over & complete page 2. Please use the space at the bottom of page 2 for additional information.

Please list all past treatments you have had for this problem (include drugs, injections, therapy, chiropractic, home remedies, etc):

Have you ever had **other injuries** to the same body parts for which you are seeing the doctor today? ☐No ☐Yes: Please give details:

All current medications: ☐None or List all:

Allergies: Do you have any? ☐No ☐Yes: List all medications you are allergic to and the nature of your reaction:

Please check all medical conditions which apply to you now or in the past::

☐Stomach problems / ulcers

☐Diabetes: A1C?_____ ☐Heart problem:_____ ☐High blood pressure

☐Asthma or breathing problem:_____ ☐Kidney disease / renal failure:_____

☐Hepatitis: ☐A ☐B ☐C ☐Liver problem:_____ ☐Previous blood transfusion ☐HIV / AIDS

☐Bleeding tendency ☐Metal allergy:_____ ☐Skin problem:_____

☐Hearing impairment ☐Hearing aids ☐Corrective glasses/lenses ☐Other visual impairment:_____

☐Seizures (epilepsy) - Last episode was:_____ ☐Frequent or severe headaches

☐Bowel or Bladder problem:_____ ☐Neuropathy: where & cause?_____

☐Balance problem or frequent falls: how long?_____ ☐Thyroid problem ☐Parathyroid problem

☐Gout ☐Lupus (SLE) ☐Arthritis: List type & all affected joints:_____

☐Osteoporosis / Osteopenia: when diagnosed & what treatment?_____

☐Vitamin D deficiency: how much are you taking?_____units/day ☐Past fractures:_____

☐Recent or current infection: Where & how was it treated:_____

☐Cancer: where/treatment?_____

Do you smoke? ☐No ☐Yes: How much?_____ **Do you drink alcoholic beverages?** ☐No ☐Yes: How much?_____

All other surgeries and hospitalizations (by date):

Significant family history of health problems:

Additional information:

Person assisting patient / translating:_____ Patient's Signature:_____

If you need additional space, check here ☐ and ask for additional sheets of paper for Medical History.