Atlantic
Medicine & Wellness

HISTORY OF COMPLAINT

Name_____ **Date**_____ **DOB** _____

Circle One : Is this an **Automobile Accident** • **Work Related** • **Fall Down** • **Regular Visit**

How did your condition come about? _____

_____

_____

When did it first occur?_____ _____

How often does it occur? _____

How long does it last? _____

Please describe the condition. List the areas of discomfort/pain, where does it start, is it the left side, right side or both and where does it travel? _____

_____

_____

_____

What brings it on? _____

_____

_____

Does anything aggravate it, increase it or make it worse? _____

_____

_____

What lessens the problem? _____

What previous treatments have you had for the condition? _____

_____

What could you do before the onset of the problem? _____

_____

What can you **not** do when you have the symptoms? _____

_____

Have you ever had these exact symptoms before? _____ If yes, when? _____

_____

MEDICAL HISTORY

List allergies: _____

_____

List all past medications: _____

_____

List all present medications: _____

_____

Previous surgeries with dates and doctors: _____

_____

_____

List any previous accidents with dates: _____

_____

Patient Signature _____ Date _____

Patient Name Case #

PERSONAL HISTORY

PERSONAL	YES	WHEN	NO	FAMILY	YES	SPECIFIC MEMBER	NO
Abdominal Bleeding							
Allergies							
Anemia							
Arthritis							
Asthma/Emphysema							
Back Disorders							
Backache							
Bleeding Diseases							
Blood in Stool/Black Stool							
Blood in Urine							
Cancer							
Change in Bowel Habits							
Chest Pain							
Colitis							
Constipation							
Cough							
Coughing Blood							
Depression							
Diabetes							
Diarrhea							
Difficulty Swallowing							
Dizziness							
Enlarged Heart							
Double Vision							
Epilepsy/Seizures							
Fainting Spells							
Gallstones							
Gall Bladder Disorder							
Glaucoma							
Headaches							
Heart Disease							
Heart Murmur							
Hepatitis							
Hoarseness							
High Blood Pressure							
Indigestion							
Irregular Heart Beat							
Kidney Infection							
Kidney Stone							
Leg Pain							
Lung Disease							
Lyme Disease							
Nocturia							
Nosebleeds							
Nervous Disorder							
Painful Urination							
Paralysis							
Phlebitis							
Pleurisy							
Pneumonia							
Rheumatic Fever							
Shortness of Breath							
Stroke							
Swelling of Feet							
Swollen/Painful Joints							
T.B.							
Thyroid Disease							
Ulcer							
Venereal Disease							
Vomited Blood							
Other							