CASE HISTORY (Comprehensive)

Name ______ Date ______ Phone ______
Address ______ City ______ State ______
Age ______ Birth Date ______ Sex ______ Marital Status ______ Zip code ______
Occupation ______ Social Security No. ______
Last Physician Consulted ______ What was Complaint ______

Employer: Email: ______
Name ______ Phone ______
Address ______

Referred by ______
Address ______
Insur. Carrier: ______

PREVIOUS HISTORY:

Measles ☐	Mumps ☐	Pneumonia ☐
Scarlet Fever ☐	Diphtheria ☐	Typhoid ☐
Pleurisy ☐	St. Vitus Dance ☐	Tonsilitis ☐
Rheumatism ☐	Whooping Cough ☐	Malaria ☐
Tuberculosis ☐	Influenza ☐	Gonorrhea ☐
Asthma ☐	Hives ☐	Hay Fever ☐
Running Ears ☐	Mental ☐	

FAMILY HISTORY:

Father L ______ D ______ Mother L ______ D ______
Brothers ______ L ______ D ______ Sisters ______ L ______ D ______
Diabetes ☐ Cancer ☐ Heart Disease ☐ Insanity ☐
Goiter ☐ Asthma ☐ Tuberculosis ☐
Stomach Disorders ☐ Kidney Disease ☐ Rheumatism ☐

OPERATIONS:

When and Where By Whom

ACCIDENTS:

HABITS:

Coffee ______ Tea ______ Tobacco ______
Alcohol ______ Drugs ______ Cathartics ______
Work ______ hrs. Sleep ______ hrs. Exercise ______

MARITAL HISTORY:

Husband-Wife
Married ______ yrs. No. of Children ______ Ages ______
No. of Pregnancies ______ Deliveries ______ Complications ______
Miscarriages ______ Accidental ______ Induced ______ Complications ______

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PRESENT COMPLAINT OR ILLNESS:

Duration ______
Method of Onset ______
How Long Since Well ______

Headache ☐ Dizziness ☐	
Loss of memory ☐ Nervousness ☐	
Unconsciousness ☐ Abnormal gait ☐	
Paralysis ☐ Change in vision ☐	
Blurring of vision ☐ Ringing in the ears ☐	
Ear ache ☐ Ear discharges ☐	
Impaired hearing ☐ Catarrh ☐	
Nose bleeds ☐ Sinus pains ☐	
Sore throat ☐ Cough ☐	
Expectoration ☐ Shortness of breath ☐	
Spitting of blood ☐ Pain in the chest ☐	
Palpitation of heart ☐ Swelling of ankles ☐	
Indigestion ☐ Abdominal pains ☐	
Belching ☐ Appetite ☐	
Nausea ☐ Vomiting ☐	
Intestinal gas ☐ Jaundice ☐	
Stool-color ☐ Stool-formation ☐	
Rectal pain ☐ Rectal bleeding ☐	
Constipation ☐ Painful urination ☐	
Burning urination ☐ Frequency Nite-Day ☐	
Blood in urine ☐ Cloudiness of urine ☐	
Soreness of genitals ☐ Discharge ☐	
Muscle pains ☐ Swelling of joints ☐	
Joint pains ☐ Backache ☐	
Numbness ☐ Skin eruptions ☐	
Itching ☐ Discoloration of skin ☐	
Abnormal sensation ☐ Change in weight ☐	