PCMI

1119 South Washington, Saginaw, MI 48601

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HEALTH HISTORY FORM

NAME: _____ **DATE:** _____

AGE: _____ **DOB:** _____ **HEIGHT:** _____ **WEIGHT:** _____

REFERRING PHYSICIAN: _____ **OTHER PHYSICIANS SEEN FOR THIS PROBLEM:** _____

PLEASE CHECK THE COORESPONDING BOX IF YOU HAVE EVER HAD ANY OF THE FOLLOWING:

High/Low Blood Pressure		Diabetes		Ulcers	
Heart Disease (heart attack, chest pain)		Hypoglycemia		Reflux	
Heart Murmur		Thyroid Disorder		Colitis	
Irregular Heart Beat (pacemaker, AICD)		Glaucoma		Diverticulitis	
Congestive Heart Failure		Blindness		Bleeding Disorder	
Mitral Valve Prolapse		Kidney Failure/Disease		Hepatitis (Type_____)	
Rheumatic Heart Disease		Bladder Problems		Jaundice	
High Cholesterol		Prostate Problems		Sickle Cell	
Deep Vein Thrombosis (blood clot)		Pulmonary Embolism		Blood Disease	
Aneurysm		Asthma		Anemia	
Stroke, TIA		Emphysema		Cancer (Type _____)	
Blackout Spells		COPD		Depression/Anxiety	
Seizures		Pneumonia		**OTHER:**	
Migraines		Sleep Apnea			
Parkinson's Disease		Home Oxygen			
Rheumatoid Arthritis		Arthritis			
Weakness/Paralysis		Hiatal Hernia		**NONE**	

Is there a possibility that you are pregnant?	Last Menstrual Period:	
Do you/have you smoked?	How much?	Date Quit?
Do you drink alcohol?	How much?	
Do you use recreational drugs?	What kind?	How often?

FAMILY HISTORY:

PLEASE LIST ANY MEDICAL CONDITIONS PRESENT IN:

Mother:
Father:
Siblings:

PREVIOUS SURGERIES/HOSPITALIZATIONS:

CURRENT MEDICATIONS **-PLEASE LIST *ALL* (PRESCIPTION, OVER THE COUNTER, HERBAL) MEDICATIONS AND DOSAGES**

NAME & DOSAGE:	NAME & DOSAGE:

SEE ADDITIONAL SHEET ☐

DO YOU TAKE ASPIRIN, NAPROSYN/ALEVE/NAPROXEN, IBUPROFEN/ADVIL/MOTRIN, PLAVIX, COUMADIN, WARAFIN OR ANY OTHER BLOOD THINNER? (IF YES, CIRCLE ALL THAT APPLY) HOW OFTEN? _____

ALLERGIES **NONE** ☐

(PLEASE LIST ALL MEDICATION, FOOD, AND OTHER ALLERGIES AND YOUR REACTION)

ALLERGEN:	REACTION:
LATEX ALLERGY? YES / NO	

SEE ADDITIONAL SHEET ☐

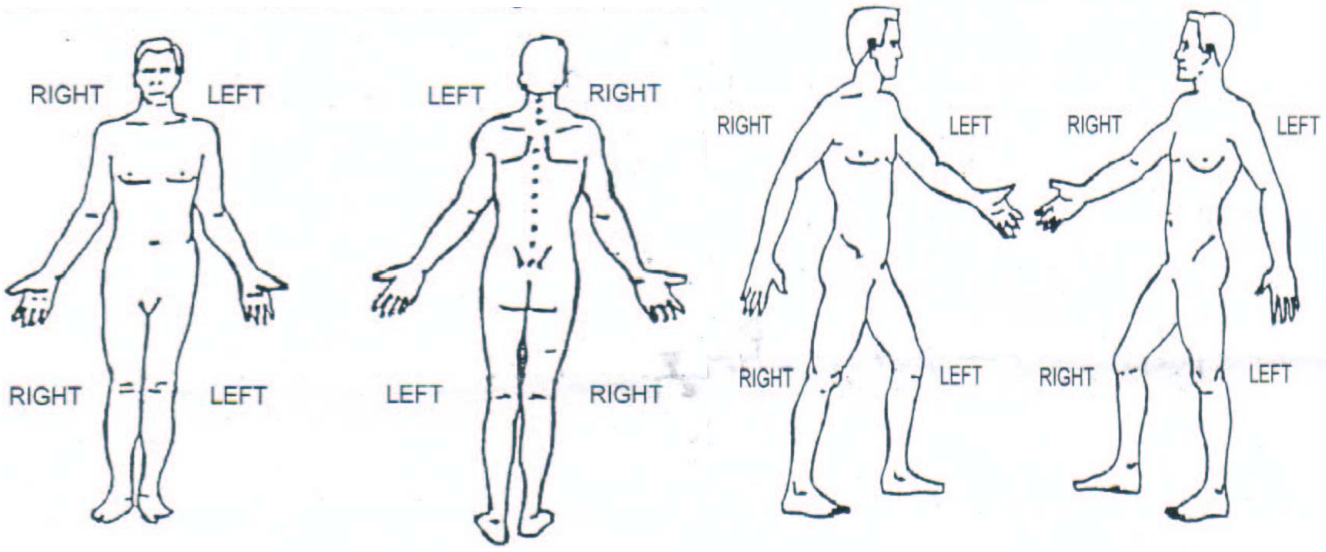
1. CHIEF COMPLAINT: _____

How long have you had this pain? _____

How did the pain begin?_____

On a scale of 1 to 10, how do you rate your pain (with 1 low and 10 high)? _____

2. PLEASE SHADE IN THE AREA ON THE DIAGRAMS WHERE YOUR PAIN IS LOCATED.



3. PLEASE CIRCLE THE APPROPRIATE WORDS THAT BEST DESCRIBE YOUR PAIN.

CONSTANT	BURNING	STABBING	COLDNESS	SHOOTING	UNBEARABLE	DULL
SHARP	HOTNESS	RADIATING	BRIEF	NUMBING	ACHING	CRAMPING
ANNOYING	INTERMITTENT	TINGLING	SEVERE	TRANSIENT	HEAVY	INTENSE

4. PLEASE INDICATE IF THE FOLLOWING INCREASES, DECREASES, OR CAUSES NO CHANGE IN YOUR PAIN.

	Increases Pain	Decreases Pain	NoChange
PHYSICAL ACTIVITY	☐	☐	☐
MOVEMENT	☐	☐	☐
STANDING	☐	☐	☐
WALKING	☐	☐	☐
SLEEP. REST	☐	☐	☐
LYING DOWN	☐	☐	☐
SITTING	☐	☐	☐
SNEEZING. COUGHING	☐	☐	☐
BOWEL MOVEMENT	☐	☐	☐
URINATION	☐	☐	☐
SEXUAL INTERCOURSE	☐	☐	☐
MASSAGE	☐	☐	☐
PRESSURE	☐	☐	☐
HEAT	☐	☐	☐
COLD	☐	☐	☐
DAMP	☐	☐	☐
WEATHER CHANGES	☐	☐	☐
EATING	☐	☐	☐
LOUD NOISES	☐	☐	☐
BRIGHT LIGHTS	☐	☐	☐

5. Please check any of the following treatments you have had for this pain problem. Include the dates and results.

	TREATMENT	PAIN RELIEF?	IF YES, LENGTH OF RELIEF	DATE
NERVE BLOCKS, EPIDURAL STERIODS	Y / N	Y / N	_____	_____
PHYSICAL THERAPY	Y / N	Y / N	_____	_____
CHIROPRACTOR	Y / N	Y / N	_____	_____
ACUPUNCTURE	Y / N	Y / N	_____	_____

6. Is your pain the result of an…

	YES	NO	If YES, explain and give dates.
ILLNESS	☐	☐	_____
ACCIDENT	☐	☐	_____
WORK RELATED	☐	☐	_____
AUTO RELATED	☐	☐	_____

7. Additional Comments: Please add any comments which you feel would help us in treating your pain.

_____

_____

_____

_____

_____

_____

_____

8. This signed authorization gives PCMI the ability to obtain, through their electronic system with Sure-scripts, all medication information and prescription benefits that are available on record with the pharmacy program:

_____

Signature of Patient

9. Pharmacy Information

Pharmacy Name:_____ Pharmacy Phone Number: _____

Pharmacy Address: _____

10. Acknowledgement of Notice of Privacy Policies

I _____ acknowledge that I have received the enclosed document from PCMI in regard to their Notice of Privacy Polilcies.

SIGNATURE OF PATIENT _____ DATE _____

Notes for Additional Health Information if Needed:

_____

_____

_____

_____

_____

_____

_____

_____

Thank you very much for taking the time to complete this form.