DEBORAH WESTERGAARD M.D.

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Initial Patient History

Patient Name: _____ Date: _____

Please describe your pain below: _____

_____

When did your pain start? _____ Is your pain: _____ Constant or _____ Intermittent

How were you injured? _____

Circle the word(s) that best describe the character of your pain:

Aching ○ Dull ○ Throbbing ○ Nagging ○ Tingling ○ Numbness ○ Burning ○ Stinging ○

Sharp ○ Stabbing ○ Tiring ○ Tender ○ Radiating ○ Other: _____

What time of the day is your pain worse? (i.e. morning, evening, etc) _____

What makes your pain better? (i.e. lying down, standing) _____

What makes yoru pain worse? (i.e. sitting still, heavy lifting) _____

Please check surgeries you have had:

Abdominal Surgery	☐	Carotid Artery	☐	Back Surgery	☐
Gallbladder	☐	Coronary Bypass	☐	Hip Surgery	☐
Appendectomy	☐	Lung Surgery	☐	Knee	☐
Laparoscopy	☐	Thyroid	☐	Carpal Tunnel	☐
Hysterectormy	☐	Tonsillectomy	☐		
Hernia	☐	Neck Surgery	☐		

Please list any other surgery you have had: _____

_____

_____

Please list all medications, including non-prescription drugs, aspirin (i.e. BC Powder, Anaoin, Bayer, etc) and herbs that you are currently taking, including strength and dosage instructions and how long you have been taking each medication:

_____

_____

_____

_____

Please list allergies: _____

_____

Are you allergic to: ☐ Iodine ☐ Seafood ☐ Benadryl ☐ Latex ☐ Tape

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Please check whether or not the following conditions apply to you:

- Fever ☐
- Skin Problems ☐
- Itching, Rashes, Moles, Warts ☐
- Bruise Easily ☐
- Vision Loss / Cataracts / Glaucoma ☐
- Redness / Itching of Eyes ☐
- Hearing Loss ☐
- Ear Infections / Ear Ringing ☐
- Anemia or Blood Disorder ☐
- Nosebleeds ☐
- Tonsil Problems ☐
- Breast Lumps / Discharge ☐
- Asthma ☐
- Shortness of Breath / Wheezing ☐
- Lung Problems / TB / Pneumonia ☐
- Cough ☐
- Do you smoke? ☐
  - If yes, how much? _____
- Did you ever smoke? ☐
- High Blood Pressure ☐
- Heaert Murmur / Heart Attack ☐
- Chest Pain / Abnormal EKG ☐
- Ulcer ☐
- Hiatal Hernia / Reflux ☐
- Hemorrhoids ☐
- Gallstones ☐
- Liver Disease ☐
- Change in Appetite / Bowel Habits ☐
- Irritable Bowel Disease ☐
- Kidney Stones ☐
- Blood in Urine ☐
- Loss of Bladder Control / Pain ☐
- Frequency / Urgency in Urination ☐
- Female / GYN
  - Last visit to GYN: _____
  - First day of last period: _____
  - Any possibility you are pregnant? ☐
- HIV or AIDS ☐
- Neck Pains ☐
- Back Pain ☐
- Problems walking ☐
- Joint Pain / Muscle Weakness ☐
- Arthritis ☐
- Broken Bones ☐

- Headaches / Seizures ☐
- Fainting / Dizziness / Stroke ☐
- Problems Speaking ☐
- Memory Problems ☐
- Paralysis ☐
- Head Injury ☐
- Nerve Injury ☐
- Diabetes ☐
- Thyroid Problems ☐
- Intolerant to Heat / Cold ☐
- Significant Weight Loss / Gain ☐
- Depression ☐
- Anxiety ☐
- Insomnia ☐
- Daytime Drowsiness ☐
- Psychiatric Problems / Treatment ☐
- Cancer ☐
- Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐
- Do you have children? ☐
- If yes, are they healthy? ☐

_____

_____

- Are you currently working? ☐
- What is your occupation? _____

_____

- How long have you been off work? ☐

_____

- Do you drink alcohol? ☐
- If so, how much? _____

_____

- Alcohol Problems? ☐
- List any lasting infections you have had: _____

_____

- Mother's health problems: _____

_____

_____

_____

- Father's health problems: _____

_____

_____

_____

List any infections you have had with in the last six months (i.e. staph, strep throat, etc) _____

_____

_____