HOLLSTROM AND ASSOCIATES, INC 11444 SEMINOLE BLVD LARGO FL 33778

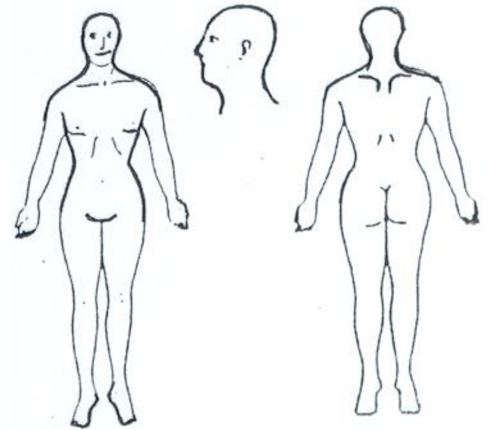
PATIENT NAME:____ **DATE**_____________________

What problem or difficulty brought you to this office?____
____
____

When did this problem start? Give Date:____

What caused this problem (an accident, injury?, details, please)____________________________________
____
____

Please mark on the figure and circle your problems below.
(Circle all that apply)



□Sharp pain □Constant pain □ Dull Ache □Pain with Movement
□Soreness □Tenderness □Weakness □ Throbbing
□ Spasm □Tightness □Stabbing □Numbness/Tingling
□ Burning □Pins and Needles Other_____________________

Have you had this problem before? Yes_____ No_____

What treatment did you have for this problem previously?
____

Has it gotten better or worse since it started? □ Same □ Better □ Worse:

How frequently do you have it? □ All of the time □ A few hours at a time □ Daily □ Occasionally

What makes it feel better? □Rest □Movement □Heat □Cold □Special Position______________________
□Medication □Other:____

What makes it feel worse? □ Standing □ Sitting □Laying Down □Walking □ Lifting □Twisting □Bending
□ Changing Positions □ Looking Up/downTurning Head □Climbing Stairs □Cough/Sneeze
□Other:____

Do you have any illness that may be causing these symptoms?_________________________________
Are you seeing anyone else for other Health Problems or conditions? □ Yes □ No
Who?_____________ What Problem?____
Who?_____________ What Problem?____
Who?_____________ What Problem?____
Do you have/had any major illnesses, injuries or diseases, now or in the past?_____________________________
____
Have you been diagnosed with Diabetes? Yes□ No□. Type 1 □ or Type 2□? When diagnosed?_________
Have you been diagnosed with Hypertension? Yes□ No□. When?_______________________
Have you been diagnosed with Osteoporosis or Osteopenia? Yes□ No□.

RATE YOUR PAIN (Circle) 0 1 2 3 4 5 6 7 8 9 10
None Mild Moderate Severe

AGE:___________ **HEIGHT**:__________________**WEIGHT**:_________________

Patient Name:____

Do you Smoke? ☐ Never ☐Former Smoker ☐Current/Every Day Smoker ☐Current Occasional Smoker
Do you exercise? ☐Heavy ☐Moderate ☐ Light What exercise do you do?_______________________________

Do you have a lot of stress? ☐ Heavy ☐Moderate ☐ Light ☐ None

How is your appetite? ☐ Good ☐ Sporadic ☐ Poor ☐ Not Hungry

Bowel Habits: ☐ Normal ☐ Irregular ☐ Constipated/Diarrhea **Bladder Habits**: ☐ Normal ☐Abnormal

What vitamins or supplements do you take?____

Are you allergic to any Food? ☐ No ☐ Yes If yes, what?____

List all prescription drugs and supplements (Including dosage) that you take:___________________________
____
(You may supply a list if you prefer)
Are you allergic to any drugs? ☐No ☐ Yes Which ones?____
Do you have Food or Environmental Allergies: ☐Yes ☐No To What?_________________________________
Do **you take, or have you ever taken:**
Prednisone, cortisone, or other steroid including injection or inhaler? ☐ Yes ☐ No

Have you ever made a Workers Compensation Claim for injury at work? Yes_____ No_____ When________

Have you ever had an Auto Accident with an injury? ☐ Yes ☐ No
When:____
Fractures? Of What?______________________ **Slip and Fall Accident**?_________________
List all Previous Surgery:____
____

List all Previous Hospitalizations____
____

What X-rays have you had in the last five years?____
Have you had an EKG in the last five years? ☐ Yes ☐ No **MRI**: ☐Yes ☐No Of What?__________________
CT Scan ☐Yes ☐ No Of What?____

Does any member of your immediate family (blood relative) have any serious disease or illness?
Relationship:__________________ Illness or Disease:____
____
Have you ever had any of the following diseases or illnesses?
☐Cancer ☐ Tuberculosis ☐Diabetes ☐Heart Trouble ☐High Blood Pressure ☐Stroke
☐Epilepsy ☐Mental Illness ☐Hepatitis ☐Transient Ischemic Attack (TIA) ☐Syncope
☐Measles ☐German Measles ☐Mumps ☐ Chicken Pox ☐ Pneumonia ☐ Pleurisy
☐Arthritis ☐Rheumatism ☐Polio ☐ Meningitis ☐ Nephritis ☐Kidney Stones
☐ Sexually transmitted Disease ☐Gallbladder Disease ☐Anemia ☐ Jaundice
☐Migraine Headaches ☐Rheumatic Fever ☐Osteoporosis
☐Chronic Obstructive Lung Disease ☐Any Bone or Joint Disease
Any Other Serious Illness or Disease not listed____
Do you have any implants, screws or plates? ☐ No ☐ Yes Where?_______________________________
Are you HIV Positive (AIDS) or do you have AID'S Related Complex? Yes_____ No_____
Have you been diagnosed with Hepatitis C? ☐ Yes ☐ No

 Patient Name:____

DO YOU HAVE NOW OR HAVE YOU HAD IN THE LAST YEAR: (Circle if YES)

☐Frequent headaches ☐Severe intensity headaches ☐Dizziness with change of position
☐Loss of Consciousness ☐Blurred Vision ☐Double vision
☐Spots before eyes ☐Infected eyes ☐Pain Between Eyes
☐Vision Changes ☐Do You Wear Glasses? Last Examined__________________________
☐Ear Aches ☐Discharge from ears ☐Ringing in ears
☐Decrease in hearing ☐Recurrent nose bleeds ☐Recurrent head colds
☐Sinus problems ☐Hay fever ☐Strange or persistent odors
☐Strange or loss of taste ☐Persistent hoarseness ☐Difficulty swallowing
☐Enlarged glands ☐Recurrent sore throat ☐Recurrent sores in mouth
☐Soreness or bleeding gums ☐Chest pain ☐Angina
☐Coughed up blood ☐Pain in arm(s) ☐Night sweats
☐Chronic cough ☐Cough when lying down ☐Night shortness of breath
☐How many pillows do you use?_________
☐Shortness of breath with ___walking several blocks, ____one flight of stairs, ____on laying down
☐Purple fingers or lips ☐Palpitations ☐High Blood Pressure
☐Swelling of hands ☐Swelling of feet ☐ Swelling of ankles
☐Leg cramps with walking ☐ Leg Cramps at night ☐Enlarged veins in legs
☐Recurrent stomach pain ☐Belching/Heartburn? Relieved by___Eating?,
☐Poor Appetite ☐Nausea ☐Vomiting
☐Avoid which foods?____
☐Abdominal cramping ☐Abnormal color bowel movement ☐Pain with Bowel Movement
☐Loss of Urine w/ coughing or sneezing ☐Difficulty starting urine stream
☐Urinate frequently ☐Urinate less frequently ☐Blood in Urine
How frequently do you urinate at night? ☐Not at all ☐________________________________
☐Joint pain ☐Swelling of joints ☐Redness/heat in joint
☐Tingling/weakness in hands/feet ☐ Less or change of sensation in hands or feet
☐Trembling of hands or feet ☐Muscle spasms ☐Muscle pain
☐Muscle cramps ☐Hot flashes ☐Tiredness with no reason
☐Brittleness of nails ☐Dryness of skin ☐Easy bruising
☐Inability to stand heat/cold ☐Change of hair texture ☐Change of skin texture

Men:
☐Discharge from penis ☐Difficulty achieving or maintaining erection ☐Pain on urination

DO YOU HAVE A PACEMAKER OR DEFIBRILLATOR? ☐ Yes ☐ No
Have you been told you have OSTEOPOROSIS OR OSTEOPENIA? By Whom?___________________

WOMEN:
ARE YOU PREGNANT? ☐Yes ☐No
Menstrual History: Age at Onset_____ Cycle:_____ (days)
Flow: ☐Heavy ☐Moderate ☐Light
Pain: ☐Yes ☐No Cramps: ☐Yes ☐No Date of Last Period______________________
Date of Last Pelvic Exam____________________ Pap Test?____________________
Vaginal discharge? ☐Yes ☐No Itching? ☐Yes ☐No Birth Control Pills? ☐Yes ☐No
Pregnancies; Number_________ Still Births____________ Premature Babies__________ C Sections___________

EVERYONE
Do you drink alcohol? ☐Heavy ☐ Moderate ☐ Light ☐None Quantity___________________
Do you use caffeine? ☐Heavy ☐Moderate ☐ Light ☐None Quantity___________________
Do you use Tobacco? ☐Heavy ☐Moderate ☐Light ☐None Quantity___________________
Do you abuse any Drugs or other Substances? ☐Yes ☐ No Which Ones______________________