HISTORY COVER SHEET

NAME:_____

AGE:_____ TODAY'S DATE_____

i) I have completed my own questionnaire ___Yes, ___ No

If the patient is unable to record their own medical history, please provide the following information:

ii) History written / recorded by:_____
Relationship to patient:_____

iii) Important questions for patient and helper / assistant:

a. If the history is written/recorded by another person, what is the reason for this assistance?

Pleases mark "X" for yes

____My eyesight is poor
____My English is not good
____I am not able to read well
____My medical problem prevents me from writing
____Other:_____

Reviewed by Dr. Banik_____ Date_____

1. MAIN PROBLEM: What is the primary problem(s) you would like help with?

2. How long ago did this problem begin? (Please be specific)

3. Why do you think this problem occurred? What are your theories?

4. Are you worried this problem could be something serious? _____Yes _____No

5. To what extent does this problem interfere with your daily activities (work, sleep, play, sex, exercise)?

6. What kind of home treatments have you tried? What kind of self-care treatments have been helpful?

7. Have you seen any kind of health care practitioner for this problem? Please list the names of any physicians, physical therapists, acupuncturists, or chiropractors.

8. Have you been given a diagnosis for this problem? _____Yes _____No

(9) Do you think that your current medical problem is due to something more serious than or different from what your doctors have told you?

___Yes ___No ___I don't know, I'm not sure

If yes, please explain:

(10) Please list other current health problems (including physical, emotional, and social concerns).

(11) Has there ever been an event, trauma, surgery, incident that has significantly or dramatically changed your life in anyway?

(12) What are your goals in coming to see Dr. Banik at this time?

(13) In general, how likely do you feel that this problem will be resolved or cured? Circle one of the following:

UNLIKELY	IMPOSSIBLE	CERTAIN	UNCERTAIN	LIKELY

(14) In general, I'd describe my health as: Circle one of the following:

EXCELLENT	VERY GOOD	GOOD	FAIR	POOR

(15) **PAST SURGICAL HISTORY/OPERATIONS**

Have you had any of the following surgeries ? Please mark "X" for yes

Tonsillectomy	Sinus Surgery of Drainage
Adenoldectomy	Wisdom Teeth Removed
Hernia repair	Appendectomy
Varicose Vein Stripping	Cosmetic Surgery
Hemorrhoid Surgery	Knee Surgery - Arthoscopic

____ Surgical implant
____ Spinal laminectomy
____ Joint replacement
____ Orthopedic surgery

MEN:
____ Vasectomy
____ Prostate Surgery

WOMEN:
____ C-Section
____ Tubal Ligation

If you checked yes to any of the above, please give the year _____

Have you had any other surgeries not mentioned above ? If you have please list them.

I have never had surgery. ____Yes, ____No. I have all my original equipment.

(16) Have you ever had any fractures/broken bones ? ____Yes, ____No
Have any fractures been set or fixed surgically ? ____Yes, ____No
Please list the bones(s) broken and the date:

(17) Do you currently use a heel lift or shoe orthotic/insert ? ____Yes, ____No

(18) Past Medical History/Illnesses

Have you ever had any of the following medical illnesses:
Please mark "X" for yes

____ Heart Attack
____ Stroke
____ Colitis
____ Kidney Disease
____ Gastritis/Stomach Inflammation
____ Stomach Ulcers
____ Cancer of any kind
____ Diabetes
____ Hepatitis
____ Arthritis of any kind

Do you have any other medical problems (current or in the past) not listed above ?

(19) Have you ever had a head injury, concussion, forceful blow to your head at any time (from birth to date) ?

____Yes, ____No If yes, please give the details of the incident and the dates.

(20) Have you ever had a fall directly on your tail bone/sacrum ? ____Yes, ____No
If, yes, please give the details of the incident and the dates.

(21) When was your last dental appointment ? _____ date
Have you ever worn braces ? ____Yes, ____No
Do you currently use a mouth brace or dental appliance for any reason ? ____Yes, ____No
Have you ever had any teeth extracted ? ____Yes, ____No

If yes, which teeth and when ? _____

(22) **X-RAYS/IMAGING HISTORY**

Have you had any of the following x-rays or Imaging studies ?

____ Chest x-ray ____Yes, ____No
____ Upper GI/Stomach X-Ray ____Yes, ____No
____ Lower GI/Colon X-Ray ____Yes, ____No
____ CAT/CT Scan ____Yes, ____No
____ MRI Scan ____Yes, ____No
____ Back X-Rays ____Yes, ____No
____ Neck X-Rays ____Yes, ____No
____ Ultrasound Exam ____Yes, ____No
____ Bone Scan ____Yes, ____No
____ Arteriogram ____Yes, ____No
____ Echocardiogram ____Yes, ____No
____ Bone Density Test for Osteoporosis ____Yes, ____No

(23) **MEDICATION HISTORY**

(a) Please list all prescription medications that you take on a *daily or regular* basis. This includes any medicine prescribed by a doctor (e.g. Thyroid, Blood Pressure Rx, Pain Medicines, Sleeping Pills, Ulcer Medicines, Inhalers, Arthritis Rx, Creams, Premarin/Provera, Birth Control Pills, Prednisone, Glaucoma drops, etc.)

(b) Please list all prescription medications that you take on an as needed basis. This includes any medicine prescribed by a doctor. (e.g. Asthma Inhalers, Pain Medicines, Allergy Medicines, Nasal Inhalers, etc.)

(c) Have you taken any of the following Over-the-Counter (OTC) medications in the past month for any reason ? (Please mark with an X for Yes)

____ Advil	____ Antihistamines	____ Laxatives
____ Nuprin	____ Decongestants	____ Colace
____ Motin-IB	____ Allergy Pills	____ Senakot
____ Ibuprofen	____ Cold/Flu Medicines	____ Exlax
____ Alleve	____ Nose Sprays	____ Milk of Magnesia
____ Naproxen	____ Cough Medicines	____ Ducolax
____ Aspirin		
____ Excedrin	____ Antacids	____ Bulk Laxatives
____ Bayer	____ Maalox/Mylanta	____ Citracil
____ Tylenol	____ Tums/Rolaids	____ Metamucil
____ Acetomenphen	____ Alka Seltzer	
____ Non Aspirin Pain Reliever	____ Bicarbonate	____ Enemas
____ Orudis KT	____ Pepto Bismal	____ Fleets
____ Pepcid AC		
____ Tagamet	____ Anti Fungus cream	____ Primatine Mist
	____ Cortisone cream	

For any OTC medicine that you marked above with an X, please give more details as to when you take the medicine and how often:

Are there any other OTC medicines not listed above that you have taken in the past month ? ____Yes, ____No If yes, please list:

(d) Please list all supplements, vitamins, minerals, herbs, or remedies that you take on a *daily or regular* basis (and explain the reason for taking each supplement/herb).

(e) Please list all supplements, vitamins, minerals, Herb's, or remedies that you take on a needed basis *(especially during the past 3 months).*

(f) Are you currently taking any Homeopathic remedies ? ____Yes, ____No

If yes, which remedy(s) ? _____

Who prescribed them ? _____

(g) Do you have any true allergies to any medications ? ____Yes, ____No
If yes, please list the drugs and reactions:

(h) Do you have any sensitivities (side effects other than allergies) to any medications ? ____Yes, ____No
If yes, please list the drugs and reactions:

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(24) My current height without shoes is: _____ feet and _____ inches.

(25) My current weight is: _____ pounds.

(26) To achieve a healthy body weight, I'd need to:
____ a. Lose about _____ pounds.
____ b. Gain about _____ pounds.
____ c. Maintain my current weight.

(27) Relationship/Marital Status:

____ Married	____Remarried	____Single
____Significant Other	____Partner	____Widow(er)
____Previous divorced, now remarried	____Spouse died, now remarried	____Divorced

(28) If you are married or in a relationship, how many years have you been with your partner ? _____ years.

(29) Do you have any children ? ____Yes, ____No
If yes, How many ? _____

(30) If applicable, do you have any grandchildren ? ____Yes, ____No
If yes, How many ? _____

(31) Education:

____ years of High School	____ years of Technical School
____ years of College	____ years Postgrad/Professional School
____ years of Apprenticeship	____ Other (please describe)

(32) Do you currently smoke cigarettes ? ____Yes, ____No

If yes, how many packs per day and for how many years total ?
____ packs, for ____ years

If yes, would you like medical help in stopping smoking ? ____Yes, ____No

(33) Have you ever smoked cigarettes in the past ? ____Yes, ____No

If yes, when did you quit ? ____ years ago

How many years did you smoke ? ____ years

And how many packs per day did you smoke ? ____ packs per day

(34) Do you drink alcohol ? ____Yes, ____No

If yes, how much daily = ____ glasses of wine/day
____ drinks/day
____ cans of beer/day

If yes, how much weekly = ____ glasses of wine/wk
____ drinks/wk
____ cans of beer/wk

(35) If you answered "Yes" to #34, have you ever:

a. Felt the need to cut down on drinking ? ____Yes, ____No
b. Felt annoyed by criticism of drinking ? ____Yes, ____No
c. Had guilty feelings about drinking ? ____Yes, ____No
d. Taken a morning "eye opener" ? ____Yes, ____No

(36) Have you ever used alcohol to help ease a painful condition ? ____Yes, ____No

(37) If you answered "No" to #34, have you ever had any problems with alcohol in the past ? ____Yes, ____No

(38) **SLEEP HISTORY**

a. How many hours do you normally sleep ? ____ hours
b. How many hours of sleep do you need to function optimally ? ____ hours
c. Do you ever have trouble sleeping ? ____Yes, ____No
d. Do you suffer from insomnia ? ____Yes, ____No
If, yes, please describe why and how often:

e. Do you ever use sleeping pills ? ____Yes, ____No
f. Do you ever use alcohol to help you sleep ? ____Yes, ____No

(39) Please list all your hobbies and recreational activities. Include: gardening, woodworking, art, sports, games, collections, etc.

(40) **STRESS HISTORY**

a. How does stress effect you ? (physically/emotionally)

b. Do you currently have stress regarding your work, home life, relationships, or other areas of your life ?

c. Do you have methods of reducing the effects of stress on your body or emotions ? (i.e. meditation, exercise, etc.)

(41) **EXERCISE HISTORY**

In an average week, I participate in some form of aerobic exercise (the kind of exercise like jogging, bicycling, swimming, or fitness walking that increases my heart rate and gives cardiovascular fitness).

____ a. Almost every day
____ b. At least three times a week
____ c. Maybe once a week
____ d. Hey, who has the time to exercise ?
____ e. My medical condition prevents me from participating in regular exercise

(42) The type of aerobic exercise(s) I engage in most often is (are) ... (Please "X" as many as apply)

____ a. Walking outdoors
____ b. Walking on a treadmill or stair climbing machine
____ c. Jogging
____ d. Swimming
____ e. Aerobic dance
____ f. Bicycling outdoors
____ g. Stationary bike
____ h. Social and/or folk dance
____ i. Other: _____

(43) In addition to aerobics, I regularly participate in:

____ a. Weight lifting with free weights
____ b. Weight lifting with weight machines
____ c. Yoga (the stretching type)
____ d. TaiChi
____ e. Other: _____

(46) **OCCUPATIONAL HISTORY**
Are you working now ?

____ a. Yes, I work in the home. (Full or Part Time ?) _____
____ b. Yes, I work outside the home. (Full or Part Time ?) _____
____ c. No, I am retired
____ d. No, I've never been employed
____ e. No, I'm not employed due to medical problems
____ f. No, I'm on disability
____ g. No, I'm out of work at this time
____ h. No, I'm a full-time student
____ i. Yes, I work full-time and I am a student
____ j. Yes, I work part-time and I am a student
____ k. Yes, I am retired and now work part-time in another job

(47) If you are not working at this time, are retired or not working for any other reason, please describe the type of work that you used to do.

(48) If you are a student, please briefly describe your course of study, the school you attend, your future plans:

(49) Where do you work ? _____
Name of company/employer: _____

(50) What is your job title ? _____

(51) Please describe in detail the type of job you have. What are your duties, responsibilities, what do you do ?

(52) If you work in the home, please describe your typical day:

(53) In addition to your regular job do you moonlight? ___Yes, ___No

If yes, describe the type of work and how many hours per week.

(54) How many total hours a week do you work on average?_____

(55) Do you work: ____Indoors ____ Outdoors ____Both

(56) Does you job schedule require that you change shifts often? For example from day to night shift? ____Yes, ___No

If yes, please explain

(57) Do you use a computer? ____ Yes, ____No

How many hours per day? ____ hours

(58) Has medical illness or pain forced you to give up or change your type of work? ___Yes ___No

(59) Have you ever missed work for the problem that you are currently seeing Dr. Banik for?

___Yes ___No

If yes, please describe in detail the injury or problem:

(60) Have you ever had a workers compensation claim for any reason in the past? ___Yes, __No

If yes, please describe in detail the injury or problem:

If there is any information not covered in this questionnaire that you would like Dr. Banik to be aware of, please add it here:

FAMILY HISTORY

Please use the form on the next page to complete a family history of diseases or illnesses. Family History is an important part of your total evaluation. If there are medical illnesses or diseases not included on the chart, please add them in. We are looking for family patterns or recurrence of illnesses. Especially note any of the following diseases: cancer, heart disease, increased cholesterol, diabetes, arthritis, epilepsy, etc. Use the space below to add any Family Medical History that cannot be included in the chart.

Please include all information you know of related to the following areas:

	Father	Mother	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age if living								
Age at death								
Cause of death								

Check any positive answer:

	Father	Mother	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Allergy: Asthma Hives Eczema								
Hayfever								
Weight Problem								
Smoker								
Alcohol Abuse								
Mental Illness								
Cancer								
Diabetes								
Hyper-tension								
Heart Problem								
High Cholesterol								
Thyroid Disease								
Blood Disease								
Bowel Problem								
Ulcers								
Arthritis								
Migraines								
Other:								