



ALLINA MEDICAL CLINIC

Allina Hospitals & Clinics

PATIENT LABEL

PATIENT HISTORY

I CHIEF COMPLAINT/REASON FOR VISIT

Please describe in detail the reason for your visit:

II HISTORY OF PRESENT ILLNESS

What are your symptoms/complaints?

How long have you had your symptoms? –or- When did this problem start?

What were you doing when your problem started?

What makes your complaints better?

Worse?

Rate your pain level 0 1 2 3 4 5 6 7 8 9 10 (0=no pain, 10= worst pain)

Rate your current level of activity 0 1 2 3 4 5 6 7 8 9 10 (0=inactive, 10=regular activities)

Please list names and dates of health care professionals you've seen for this problem:

None or

What tests, treatments and/or medications have you had so far?

None or

Did you ever have this problem before?

Yes No If Yes, describe when and how treated?

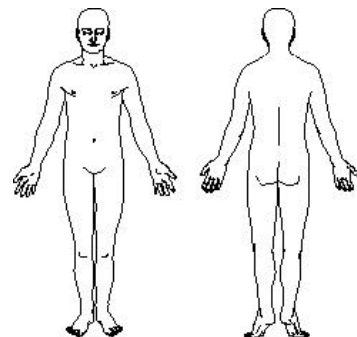
Do you have leg and/or arm symptoms? Describe

Have you filed a Work Comp or MVA claim or hired an attorney? None or (circle all that apply)

Using the symbols below, please mark the areas on the diagram where you feel sensations. Please be sure to indicate all areas affected by the sensations.

Sore or painful XXXX	Numbness/Tingling OOOOOO	Burning/Stabbing //////
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Are these sensations: Intermittent Constant



PATIENT HISTORY (con't)

NAME:

DOB:

MR#:

List any MEDICATION you use regularly:	List any ALLERGIES/ADVERSE REACTIONS you have including drugs such as penicillin:
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III PAST HISTORY

Are you currently under the care of a physician for any reason? Yes No If Yes, please explain:

List past **HOSPITALIZATIONS, OPERATIONS OR SERIOUS ILLNESSES**:

Type of Illness or Operation	Month and Year	Name of Hospital or Doctor	City and State

Immunization Status: Tetanus Yes No If Yes, Date:

IV WORK HISTORY

Job Title/Occupation:	Describe tasks/activities for this job:	# of years doing this job?	# of years w/employer?

V SOCIAL HISTORY

Marital Status:

Single Married Widowed Divorced

Please list home activities or hobbies, sports or other recreational activities that you engage in on a regular basis?

Do you use the following:

Yes No Tobacco Type (please circle): cigarettes cigars pipe other Freq (avg/wk): _____

Yes No Alcohol Type (please circle): beer wine other Freq (avg/wk): _____

VI REVIEW OF SYSTEMS

Please check if you are suffering from any of the following:

General Health

- Weight Loss
- Fatigue/being tired
- Fever
- Night Pain

Eyes, Ears, Nose, Throat

- Glaucoma –or–
- Blurred vision
- Trouble with eyes
- Swollen glands

Respiratory

- Shortness of breath
- Asthma
- Chronic cough
- Lung disease

Cardiovascular

- Heart problems
- High blood pressure
- Stroke

Skin

- Skin rashes

Intestinal System

- Ulcers/Gastritis (with or w/o medications)
- Liver disease
- History of Hepatitis
- Loss of bowel control

Musculoskeletal

- Arthritis/joint swelling
- Muscle weakness

Nervous System

- Seizures
- Epilepsy
- Headaches

Psychological

- Depression

Endocrine

- Diabetes
- Thyroid Disease

Hematological

- Anemia
- Bleeding tendencies

Urological

- Kidney problems
- Bladder control problems

Please identify any significant family medical history (i.e. heart disease, diabetes, arthritis):

If you are experiencing persistent symptoms for any of these, please follow up with your personal physician.