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PATIENT CASE HISTORY

Name _____ Social Security # _____ DOB _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____

Occupation _____ E-mail _____

HEALTH INFORMATION

What is your main complaint? _____

Other complaints: _____

How long have you had this condition? _____ Have you had this or similar conditions before? _____

Is your pain or condition getting worse? _____ Constant? _____ Comes and goes? _____

What things aggravate or bring on your condition? _____

What things improve your condition? _____

What other doctors have you seen for this? _____

Please list any past surgical operations and their dates: _____

Please list any medications currently taken: _____

What would you like to see change from your care at this office? _____

Signature _____