PATIENT HEALTH INFORMATION

Are you currently on or have you been on Methadone Therapy? [ ] Yes [ ] No

FAMILY HISTORY:	Diabetes	Heart	Kidney	Cancer	Back Conditi
Mother: Living or Deceased	[ ]	[ ]	[ ]	[ ]	[ ]
Father: Living or Deceased	[ ]	[ ]	[ ]	[ ]	[ ]
Brother (s) # of _____	[ ]	[ ]	[ ]	[ ]	[ ]
Sister (s) # of _____	[ ]	[ ]	[ ]	[ ]	[ ]

DAILY HABITS:

Smoking: [ ] Yes [ ] No
Coffee: [ ] Yes [ ] No Cups/day____
Alcohol Consumption [ ] Yes [ ] No Cups/day_____
Soft Drinks [ ] Yes [ ] No Cups/day_____

EXERCISE: [ ] NONE [ ] LIGHT [ ] MODERATE [ ] DAILY

Have you had or do you have any of the following:

[ ] Spinal strain/sprain [ ] Cancer [ ] Anemia [ ] Arthritis [ ] Goiter
[ ] Rheumatic Fever [ ] Epilepsy [ ] Diabetes [ ] Scoliosis [ ] Pneumonia
[ ] Addictions [ ] Whiplash [ ] Polio [ ] Pleurisy [ ] HIV Positive
[ ] Alcoholism [ ] Heart Disease

Please check if you have had any of the following conditions in the last 6 months:

GENERAL SYMPTOMS
___ 784.0 Headache
___ 780.6 Fever
___ 780.99 Chills
___ 780.8 Night Sweats
___ 780.2 Fainting
___ 780.4 Dizziness
___ 780.3 Convulsions
___ 780.52 Loss of Sleep
___ 780.7 Fatigue
___ 799.2 Nervousness
___ 783. Loss of Weight
___ 782. Numbness or pain in arms/legs/hands
___ 995.3 Allergy (What)
___ 786.07 Wheezing
___ 729.2 Neuralgia

MUSCLES & JOINTS
___ 728.9 Weakness
___ 781.0 Twitching
___ 723.5 Stiff Neck
___ 724.5 Backache
___ 719.0 Swollen Joints
___ 781. Tremors
___ 729.5 Foot Trouble
___ 724.79 Painful Tail Bone
___ 724.5 Pain Between Shoulders
___ 737.3 Spinal Curvature

GASTRO-INTESTINAL
___ 783. Poor Appetite
___ 536.8 Poor Digestion
___ 994.2 Starvation
___ 787.3 Belching or Gas
___ 787.0 Nausea
___ 787.0 Vomiting
___ 578.0 Vomiting Blood
___ 536.8 Pain over Stomach
___ 564.0 Constipation
___ 787.91 Diarrhea
___ 562.1 Colon Trouble
___ 455.6 Hemorrhoids (Piles)
___ 776.7 Fluid Retention
___ 873.9 Liver Trouble
___ 274. Gout
___ 782.4 Jaundice
___ 575.9 Gall Bladder Trouble

CARDIO-VASCULAR
___ 785.0 Rapid Heart
___ 427.89 Slow Heart
___ 401.9 High Blood Pressure
___ 458.9 Low Blood Pressure
___ 786.51 Pain Over Heart
___ 429.9 Heart Trouble
___ 719.07 Swelling Ankles
___ 459.9 Poor Circulation
___ 454.9 Varicose Veins
___ 436. Strokes
___ 785.1 Palpitations

EYE/EAR/NOSE/THROAT
___ 368.9 Poor Vision
___ 378.0 Crossed Eyes
___ 379.91 Pain in Eyes
___ 389.9 Deafness
___ 388.70 Earache
___ 388.30 Ear Noises
___ 388.60 Ear Discharges
___ 478.1 Nasal Obstruction
___ 784.7 Nose Bleeds
___ 462. Sore Throats
___ 784.49 Hoarseness
___ 477.9 Hay Fever
___ 493.9 Asthma
___ 460. Frequent Colds
___ 240.9 Enlarged Thyroid
___ 463. Tonsillitis
___ 473. Sinus Trouble

SKIN OR ALLERGIES
___ 680. Skin Eruptions – No
___ 698.9 Itching
___ 924.9 Bruising Easily
___ 701.1 Dryness
___ 680.9 Boils
___ 782. Sensitive Skin
___ 708.9 Hives or Allergy
___ 692.9 Eczema
___ Medicines
_____
_____

RESPIRATORY
___ 786.2 Chronic Cough
___ 786.3 Spitting Blood
___ 786.4 Spitting Phlegm
___ 786.50 Chest Pain
___ 786.09 Difficulty Breathing

GENITO-URINARY
___ 788.4 Frequent Urination
___ 788.1 Painful Urination
___ 599.7 Blood in Urine
___ 590. Kidney Infection
___ 788.3 Bed Wetting
___ 788.3 Inability to control Urine
___ 601.9 Prostate Trouble

FOR WOMEN ONLY
___ 625.3 Painful Periods
___ 626.2 Excessive Flow
___ 626.4 Irregular Cycle
___ 627.2 Hot Flashes
___ 625.3 Cramps or Backaches
___ 623.5 Vaginal Discharge
___ Pregnant at this Time
___ Last Pap
By Whom _____
Other _____