

DIAGNOSTIC EVALUATION FORM

DATE _____

①

Name _____ Birthdate _____

Insurance Carrier _____

Referred by _____ Date _____

②

History _____

③

PH – Please list the following:

Surgery - _____

Injuries - _____

Hosps - _____

Drug Reactions - _____

Childhood diseases - _____

Illness – Please circle any of the following you have had:

④

SYSTEMS (Please circle any of the following you are having or have had trouble with and fill in spaces marked with*):

Weight

*Max _____

*Min _____

*Change _____

Head

Headache _____

Light-headed _____

Fainting (Synope) _____

Other _____

Eyes

Glasses _____

Vis. Symp. _____

Blurred Vision _____

Double Vision _____

Pain in Eyes _____

Other _____

Genitourinary

Frequent urination _____

*Average number of time get up to urinate at night _____

Decrease in urinary stream _____

Incontinent _____

Bleeding in urine _____

Stone _____

Infect _____

Venereal Disease _____

Gynecologic

*Age at onset of menses _____

*Date or age of last menstrual period _____

*No. of pregnancies _____

*No. of miscarriages _____

Complication of pregnancies _____

Menses _____

Menopausal sympt _____

Ear, Nose, Throat

Hearing _____
Perforation _____
Dizziness _____
Ringing in Ears _____
Sinusitis _____
Tonsillitis _____
Hoarseness _____
Nosebleeds _____
Other _____

Teeth / Gums

Dentures _____
*Last Exam _____

Cardiorespiratory

Dyspnea (shortness of breath) _____
Orthopnea (shortness of breath lying down) _____
Noct. Dysp. (shortness of breath at night) _____
Chest pain _____
Palpitation _____
Murmur _____
Hi BP _____
Cough _____
Coughing blood _____
Sputum _____
Wheeze _____
Asthma _____
Other _____

Gastrointestinal

*Appetite _____
Nausea _____
Vomiting _____
Diarrhea _____
Constipation _____
Bleeding from intestine _____
Excessive gas _____
Change in bowel habit _____
History of ulcer _____
History of jaundice _____
History of colitis _____
Abdominal pain _____

Endocrine

Heat intolerance _____
Flushing _____
Skin disease or rashes _____
Nails _____
Thirst _____
Sugar in urine _____
Libido _____
Potency _____

Blood Disorders

Anemic _____
Blood disorder _____
Bleeding tendency _____
Abnormality of red cells _____
Abnormality of white cells _____
Abnormality of platelets _____

Musculoskeletal

Muscle Cramps _____
Pain _____
Swelling _____
Arthritis _____
Neck Pain _____
Back Pain _____
Injuries _____

Vascular

Pain _____
Edema _____
Varicosities _____
Thrombosis _____
Phlebitis _____

Allergies - Sensitivities

Rhinitis _____
Asthma _____
Skin _____
Reactions _____

Social

Habits _____
Work _____
Recreation _____
Travel _____
Alcohol _____
Tobacco _____

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FAMILY HISTORY

	Age	Alive Or Dead	Status of health or Cause of death
Father			
Mother			
Grandparent			
Brothers & Sisters			

Circle any of the following that are in members of your family (parents, siblings, grandparents, aunts, or uncles).

Tuberculosis _____
Heart Disease _____
High Blood Pressure _____
Diabetes _____
Gout/Arthritis _____
Cancer _____
Allergy _____
Psychiatric _____
Devel. abn. _____
Other _____