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Initial Visit History

Where on your body is the problem? _____

Where did you hear about Dr. Mikulak? _____

Describe the problem, please circle the applicable symptom:

Please give a brief history of how

Quality of pain - sharp dull throbbing aching shooting

problem occurred:

Severity of pain - minor moderate severe

Duration - intermittent constant lasting minutes hours days

Onset - when did the pain begin? _____

Timing - with certain activities at night only

Context - worsening plateaued improving

Modifying factors - rest heat ice elevation medications therapy

Do they help? _____

Associated signs and symptoms - bruising numbness weakness tingling

Have you had any of the following? If yes, please check and describe briefly.

___ Fever ___ Chills ___ Other Bone ___ Joint ___ Muscle Pains

___ Sinus ___ Mouth ___ Ear Infections ___ Birth marks ___ Burns ___ Scars

___ Dentures ___ Loss of Consciousness ___ Chest Pain

___ Blood Clots ___ Shortness of Breath ___ Numbness

___ Weakness ___ Dizziness ___ Depression ___ Anxiety ___ Ulcers

___ Low Blood Count ___ Easy Bruising ___ Bleeding

___ Menopause ___ Taking Hormones ___ Skin or Eyes Turn Yellow

___ Urinary Incontinence ___ Problems with Frequent Infections

Patient Date of Birth _____ Age _____ Height _____ Weight _____

Patient Name _____ Date _____ (over)

List all past and present medical problems:

List current medications and dosages for each condition:

List year and reason for all hospitalizations excluding surgery:

List all surgeries, the years they were performed and which hospital:

List allergies and describe your reaction (for example, penicillin - rash)

Marital Status M S W D

Family History and Relationship:

Occupation, present or former if retired _____

 Hereditary disorders
 Cancer

Hobbies or Activities _____

 Heart disease
 Diabetes
 High blood pressure
 Lung disease

How much and what type of the following do you use per day?

Tobacco _____

Drugs _____

Alcohol _____

Caffeine _____

Patient Name _____ Date _____