Anderson Integrative Medicine, PLLC
3031 S. Russell St. Missoula, MT 59801
Phone: (406) 493-0712 Fax: (406) 327-6702
email: matt@andersonmedicine.com

Patient History - 1

Date _____

Name_____ DOB_____

Address_____ Day Phone_____
Street

_____ Eve. Phone_____
City State Zip

Problem List (symptoms or complaints) Date Began

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Medical Tests For Above (XRays, MRIs, CAT scans, Blood Test or other)

Date Facility Result

_____
_____
_____
_____

Past Medical Problems and Hospitalizations

Date Reason

_____
_____
_____

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Patient History - 2

Medications Currently Used

Name	Date Began	Reason

Past Surgeries

Date	Reason	Outcome

Medication Allergies

Name	Reaction

Birthplace_____ Residence past 5 years_____

List all states lived in_____

Occupation_____ For how long_____

( )Married ( )Single ( )Divorced ( )Separated ( )Widowed

Highest Level of Education Completed? Grade School High School College Masters Doctorate Professional

Alcohol Use (Drinks per day)_____ Type of Alcohol_____

Size of typical drink in ounces_____ Problems with Alcohol NO YES UNSURE

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Patient History - 3

Tobacco Use YES NO

Type Used_____ Amount per day_____Years_____

Caffeinated Beverages YES NO

Type Used_____ Amount per day_____Years_____

Water Intake Amount per day_____

Pain Reliever Use YES NO

Type Used_____ Amount per day_____Years_____

Illicit Drug Use YES NO

Type Used_____ Amount per day_____Years_____

Family History				Illnesses
Father	____Living	____Deceased	Age_____	_____
-Grandfather	____Living	____Deceased	Age_____	_____
-Grandmother	____Living	____Deceased	Age_____	_____
Mother	____Living	____Deceased	Age_____	_____
-Grandfather	____Living	____Deceased	Age_____	_____
-Grandmother	____Living	____Deceased	Age_____	_____

Date of Last: Full Physical Exam _____ Blood Test _____

General
Fever Chills Sweats Weight Loss Weight Gain Night Sweats Fatigue

Skin
Dryness Itching Rashes Acne Growths Bruising

Nails
Ridging Brittle Discolored

Lymph Nodes
Swollen Glands Painful

Endocrine
Change in Appetite Sensitive to heat or cold Extreme Thirst Increased Urination

Head
Headaches, Migraine, trauma, dizziness, fainting, seizures

Eyes
Blurring Glasses Contacts Surgery Cataracts Pain

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Patient History - 4

Ears
Deafness tinnitus spinning sensations drainage pain
Nose
Sinus infections congestion bleeding blockage use of over-the-counter nasal sprays
Mouth
Canker sores, gum bleeding, toothaches, mercury fillings, pulled teeth, braces, retainers
Other dental procedures_____
Throat
Soreness loss of voice change in voice
Neck
Swelling swollen glands stiffness
Breasts
Lumps, pain, nipple discharge, Date of last mammogram_____result_____
Respiratory
Difficulty breathing: with exercise at night when lying down
Wheezing, cough, mucus, blood, painful breathing, tuberculosis exposure, pneumonia, asthma, emphysema
Cardiovascular
Chest pain or tightness, skipped heartbeats, swelling in feet or belly, cold feet
Pain in legs when walking helped by resting, blue toes or fingers, high blood pressure, history of rheumatic fever, heart murmurs
Gastrointestinal
Painful swallowing, difficulty swallowing, nausea, vomiting,
bloody or coffee ground appearing vomit, pain in abdomen, jaundice, diarrhea, constipation, bloody stools, tarry stools, hemorrhoids, rectal pain, hernia
Genitourinary
Frequent urination, absent urination, painful urination, bloody urine, pus in urine
Incontinence of urine, frequent urination at night
Pain in sides, kidney stones, history of bladder or kidney infection.
Women Only: Age at start of periods_____
Age of end of periods_____
If still having periods: Are they regular_____
How long are your cycles_____
Date of last Pap Smear_____ Results_____
Number of pregnancies_____ Dates_____
Births_____ Episiotomies_____
Neurological
Weakness, paralysis, numbness, shakes, seizures, tingling
Mental Status
Mood swings, depression, difficulty sleeping, sleeping too much, delusions, hallucinations

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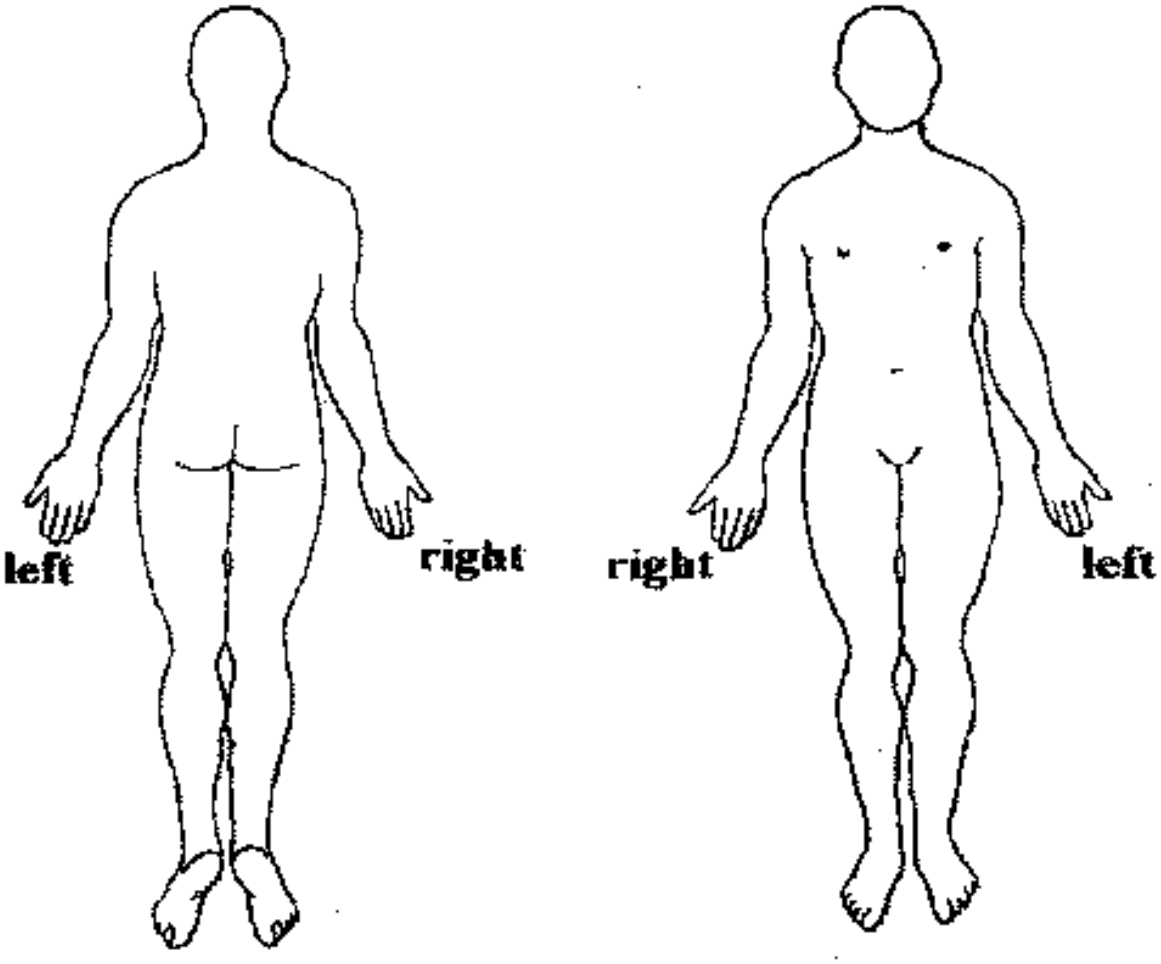
Pain Diagram

Name _____ Date _____

Draw the location of your pain on the body outlines below. Use the appropriate colored pencil (or letter code) to denote the kind of pain you are having now. Using a pen, draw all scars that are on your body.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER	SCARS(++)
Brown	Red	Blue	Orange	Green	Yellow	Pen (ink)
Or A	B	N	P	S	O	



No pain (----------) Worse possible pain

Please mark on the pain line what you feel your average pain is.