

Ottawa Village Chiropractic, PLC
Greg Lynas, DC

PATIENT NAME: _____

Do you have vertigo (dizziness)?	Yes _____	No _____
Do you pass out easily (faint or loss of consciousness)?	Yes _____	No _____
Do you have double vision or have you lost sight in one eye?	Yes _____	No _____
Do you have any slurred speech or difficulty with speech?	Yes _____	No _____
Do you have indigestion or difficulty swallowing?	Yes _____	No _____
Do you have any difficulty walking, with coordination or falling to one side?	Yes _____	No _____
Do you have nausea or vomiting?	Yes _____	No _____
Do you have numbness on one side of your face or body?	Yes _____	No _____
Do you have any visual disturbances or rapid eye movement?	Yes _____	No _____
Do you have or have you ever had difficulty in arranging words properly?	Yes _____	No _____
Do you have a headache or head pain that is unlike any you have had before?	Yes _____	No _____
Do you have headaches for hours or days?	Yes _____	No _____
Do you have a history of stroke in your family?	Yes _____	No _____
Do you have chest pain?	Yes _____	No _____
Do you have any change in bowel or bladder habits?	Yes _____	No _____
Do you have a sore that does not heal?	Yes _____	No _____
Do you have any unusual bleeding or discharge?	Yes _____	No _____
Do you have any thickening in your breasts or elsewhere?	Yes _____	No _____
Do you have a change in any wart or mole?	Yes _____	No _____
Do you have a nagging cough or hoarseness?	Yes _____	No _____
Do you have night sweats?	Yes _____	No _____
Do you have pain in neck, jaw or face?	Yes _____	No _____
Do you have a drooping eyelid or change in your pupils?	Yes _____	No _____
Do you have any ringing in your ears?	Yes _____	No _____
Do you take birth control pills?	Yes _____	No _____
What prescription medication are you taking if any?		
[] High blood pressure medication		
[] Blood thinners		
[] Herb, vitamins, or over the counter products		
[] Other _____		

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Have you ever had cancer? Yes ___ No ___
Does your pain ever wake you from a sound sleep? Yes ___ No ___
Are you losing weight now without trying? Yes ___ No ___
Are you coughing up blood or noticing it in your stools or urine? Yes ___ No ___
Have you had any loss of bladder or bowel control? Yes ___ No ___
Have you lost consciousness or had double vision recently? Yes ___ No ___
Are you seeing any other doctor now for any reason? Yes ___ No ___

Note: _____
Are you taking any medication or over-the-counter drugs? Yes ___ No ___
Please indicate type (aspirin, etc.) _____
Are you taking herbs, nutraceuticals, botanicals, or vitamins?
Please list _____
What was the date of onset of your last menses? _____

Social History

SMOKER _____ Yes or _____ No, If Yes, how many packs _____
ALCOHOL _____ Yes or _____ No, If Yes, how much _____

Family History

Did your mother or father have any of the following:
Put an **M** for mother, **F** for father, and **B** for both.

- | | |
|-------------------------|---|
| () High Blood Pressure | () Ulcer or Stomach Problems |
| () Heart Attack | () Stroke (Please indicate age when stroke occurred,
Mother _____ Father _____) |
| () Emphysema | () Arthritis-Rheumatism |
| () Seizure-Convulsions | () Mental Illness |
| () HIV Positive | () Thyroid Disease |
| () Asthma | () Circulation Problems |
| () Diabetes | () Cancer |
| () Kidney Disease | |

Comments: _____

