Jacqueline M. Stoken, D.O., P.C.
1454 30th St., Ste 109
West Des Moines, IA 50266
Tel: (515) 327-0046; Fax (515) 327-9389

PATIENT HISTORY

Patient Name _____ Date _____

Referred By / How did you hear about us? _____

Reason for visit _____

General Health Review

Medical History (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, asthma, osteoporosis, abnormal bleeding, mental illness, HIV, hepatitis, etc.)

_____ _____ _____
_____ _____ _____

Surgical History (**unrelated** to pain; such as appendectomy)

_____ _____ _____
_____ _____ _____

Surgical History (**related** to pain; such as laminectomy)

_____ _____ _____
_____ _____ _____

Family History (heart disease, stroke, cancer, arthritis, diabetes, hypertension, asthma, osteoporosis, abnormal bleeding, mental illness, etc.)

_____ _____ _____
_____ _____ _____

Allergies (include medication and food allergies)

_____ _____ _____
_____ _____ _____

Intolerances (include side effects from previous medications, such as gastritis, nausea, constipation, etc.)

_____ _____ _____
_____ _____ _____

Current Medications (include vitamins and birth control pills, if applicable)

_____ _____ _____
_____ _____ _____

Do you have any of the following? (*Circle all that apply*)

Headaches	Stomach Pain	Chest Pain	**Female**		
Vision Problems	Nausea	Shortness of Breath	Pregnancies _____	Last Menstrual Period ____	Length of Flow _____
Hearing Problems	Vomiting	Urinary Problems	Live Births_____	Last Pap _____	Length of Cycle _____
Dizziness	Constipation	Rashes	Miscarriages_____	Last Mammogram _____	Pain/Bldg w intercourse ___
Difficulty Swallowing	Diarrhea	Swollen Joints	Birth Control _____	Irreg Period ____	PMS (Medium to Severe)____
Swollen Joints	Anxiety or Depression	Chronic Fatigue	Age of Menses Onset ___	Flow Lt/Mod/Heavy ____	Hot flashes/Night Sweats ___
Cough	Sinus Problems	Sleeping problems		Vaginal Dryness _____	Change in sex drive ____

Domestic Situation

With whom do you live? _____

Are there any substance abuse issues in the household? Yes_____ No_____

If yes, please explain_____

Are you able to take care of yourself? Yes_____ No_____

If not, please enter name of caregiver_____

Work History

Job Years worked Why did you leave?

_____

_____

Legal Matters

Are you presently involved in a lawsuit? Yes_____ No_____ If yes, please explain.

_____

_____

Substance Use

Which of the following drugs or substances, if any, have you used in the past? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you used it occasionally ("O"), frequently ("F"), or continuously ("C").

Alcohol_____	Barbiturates_____	Cocaine _____
Heroin _____	Amphetamines ____	Marijuana _____
Other _____	Other_____	Other_____
(specify)	(specify)	(specify)

Are you presently using any of the drugs or substances below? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you use it occasionally ("O"), frequently ("F"), or continuously ("C").

Alcohol_____	Barbiturates_____	Cocaine _____
Heroin _____	Amphetamines ____	Marijuana _____
Other _____	Other_____	Other_____
(specify)	(specify)	(specify)

Do you presently smoke cigarettes or use tobacco in any form? Yes_____ No_____

If not, did you ever smoke cigarettes or use tobacco in any form? Yes_____ No_____

How many packs do (did) you smoke a day? _____ For how many years? _____