Lawrence A. Schaeffer, M.D

(Please fax all paperwork to 806-467-1063 at least five days before your appointment)

HISTORY OF PRESENT ILLNESS: Please explain the CHIEF complaint that brought you in today. (Include when and how this started and things that may trigger the problem or make it better.)

_____
_____
_____
_____
_____
_____
_____

PATIENT MEDICAL HISTORY

Yes No High Blood Pressure
Yes No Diabetes Mellitus
Yes No Thyroid Disease
Yes No Heart Disease
Yes No Pacemaker or ICD
Yes No COPD
Yes No Stroke
Yes No Headaches
Yes No Neck Problems
Yes No Back Problems
Yes No Previous Head Injury
Yes No Multiple Sclerosis
Yes No Epilepsy/Seizures
Yes No Rheumatoid Arthritis
Yes No Osteoarthritis
Yes No Fibromyalgia
Yes No Lupus

Yes No Sleep Apnea/Snoring
Yes No Depression
Yes No Anxiety
Yes No Bipolar Disorder
Yes No Ulcers
Yes No Irritable Bowel Syndrome
Yes No Acid Reflux
Yes No Liver disease
Yes No High Cholesterol or Lipids
Yes No Kidney Disease
Yes No Glaucoma
Yes No Anemia
Yes No Cancer Type _____
Yes No Shingles
Yes No Other Medical Conditions

_____
_____

Have you had any MRIs, CT/CAT scans, or blood work done in the past year? If so, where were they done? _____
_____
_____

CURRENT MEDICATIONS (Name, strength, and how often)**:**

_____
_____
_____
_____
_____
_____
_____
_____

Patient Name:_____ Date:_____

DRUG ALLERGIES:

_____
_____
_____

PAST SURGICAL PROCEDURES:

_____
_____
_____
_____
_____
_____
_____
_____

PAST INJURIES (broken bones, head or spine injuries, car/motorcycle accidents, etc):

_____
_____
_____
_____

PAST MEDICAL AND PSYCHIATRIC HOSPITALIZATIONS:

_____
_____
_____
_____
_____

Are you? RIGHT handed, LEFT handed or BOTH (please circle one)

MEDICAL EQUIPMENT USED:

_____
_____

FAMILY HISTORY

Please list the current health problems (if any) of any of the following living relatives. For those who are deceased, please give any health problems and cause of death if known.

FATHER: Age___ Living or Deceased Health conditions:_____
_____
_____

MOTHER: Age___ Living or Deceased Health conditions: _____
_____
_____

Patient Name:_____ Date:_____

SIBLINGS (List ages and health conditions)**:**

_____
_____
_____

CHILDREN (List ages, sex, and health)**:**

_____
_____
_____

OTHER RELATIVES (List any other relatives who may have related diseases such as diabetes, thyroid problems, nerve disorders like neuropathy, heart problems, cancer):

_____
_____
_____
_____
_____

SOCIAL HISTORY

Highest level of education you achieved: _____

Marital status: M W D S (Please circle)

What kind of work do you? _____

What exercise do you do regularly, if any? _____

Do you smoke or use smokeless tobacco? Yes____ No____ Quit_____(list year quit)
If yes, how much?_____
If you quit, approximately how much did you smoke and for how long? _____
_____

Do you drink any alcoholic beverages? _____ How much?_____

Do you drink any caffeinated beverages? _____ How much?_____

Have you ever been exposed to any infections or toxins at work or in the past?_____
If so, what were you exposed to? _____

Patient Name:_____ **Date:**_____