



DEBORAH WESTERGAARD M.D.

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Initial Patient History

Patient Name: _____ **Date:** _____

Please describe your pain below: _____

When did your pain start? _____ Is your pain: _____ Constant or _____ Intermittent

How were you injured? _____

Circle the word(s) that best describe the character of your pain:

Aching Dull Throbbing Nagging Tingling Numbness Burning Stinging

Sharp Stabbing Tiring Tender Radiating Other: _____

What time of the day is your pain worse? (i.e. morning, evening, etc) _____

What makes your pain better? (i.e. lying down, standing) _____

What makes your pain worse? (i.e. sitting still, heavy lifting) _____

Please check surgeries you have had:

Abdominal Surgery Carotid Artery Back Surgery

Gallbladder Coronary Bypass Hip Surgery

Appendectomy Lung Surgery Knee

Laparoscopy Thyroid Carpal Tunnel

Hysterectomy Tonsillectomy

Hernia Neck Surgery

Please list any other surgery you have had: _____

Please list all medications, including non-prescription drugs, aspirin (i.e. BC Powder, Anaoin, Bayer, etc) and herbs that you are currently taking, including strength and dosage instructions and how long you have been taking each medication:

Please list allergies: _____

Are you allergic to: Iodine Seafood Benadryl Latex Tape



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Please check whether or not the following conditions apply to you:

Fever	[]	Headaches / Seizures	[]
Skin Problems	[]	Fainting / Dizziness / Stroke	[]
Itching, Rashes, Moles, Warts	[]	Problems Speaking	[]
Bruise Easily	[]	Memory Problems	[]
Vision Loss / Cataracts / Glaucoma	[]	Paralysis	[]
Redness / Itching of Eyes	[]	Head Injury	[]
Hearing Loss	[]	Nerve Injury	[]
Ear Infections / Ear Ringing	[]	Diabetes	[]
Anemia or Blood Disorder	[]	Thyroid Problems	[]
Nosebleeds	[]	Intolerant to Heat / Cold	[]
Tonsil Problems	[]	Significant Weight Loss / Gain	[]
Breast Lumps / Discharge	[]	Depression	[]
Asthma	[]	Anxiety	[]
Shortness of Breath / Wheezing	[]	Insomnia	[]
Lung Problems / TB / Pneumonia	[]	Daytime Drowsiness	[]
Cough	[]	Psychiatric Problems / Treatment	[]
Do you smoke?	[]	Cancer	[]
If yes, how much? _____		Marital Status: Single []	
Did you ever smoke?	[]	Married []	
High Blood Pressure	[]	Divorced []	
Heart Murmur / Heart Attack	[]	Widowed []	
Chest Pain / Abnormal EKG	[]	Do you have children?	[]
Ulcer	[]	If yes, are they healthy?	[]
Hiatal Hernia / Reflux	[]	_____	
Hemorrhoids	[]	_____	
Gallstones	[]	Are you currently working?	[]
Liver Disease	[]	What is your occupation? _____	
Change in Appetite / Bowel Habits	[]	_____	
Irritable Bowel Disease	[]	How long have you been off work?	[]
Kidney Stones	[]	_____	
Blood in Urine	[]	Do you drink alcohol?	[]
Loss of Bladder Control / Pain	[]	If so, how much? _____	
Frequency / Urgency in Urination	[]	_____	
Female / GYN		Alcohol Problems?	[]
Last visit to GYN: _____		List any lasting infections you have had: _____	
First day of last period: _____		_____	
Any possibility you are pregnant?	[]	Mother's health problems: _____	
HIV or AIDS	[]	_____	
Neck Pains	[]	_____	
Back Pain	[]	_____	
Problems walking	[]	Father's health problems: _____	
Joint Pain / Muscle Weakness	[]	_____	
Arthritis	[]	_____	
Broken Bones	[]	_____	
List any infections you have had with in the last six months (i.e. staph, strep throat, etc) _____			
