

**Patient History Form**

**NAME** (print): \_\_\_\_\_

Referred here by: (check one)     self     family     friend     doctor     attorney

Name of Person/Physician making referral: \_\_\_\_\_

Primary Care Physician/Family Doctor: \_\_\_\_\_

Please describe the reason for your visit: \_\_\_\_\_ Body Part \_\_\_\_\_ right left both

Acute Injury-new (circle one)    yes    no    Chronic Symptoms-old (circle one)    yes    no

How did your symptoms begin? If sudden, describe onset: \_\_\_\_\_

On a scale of 1-10 (10 being most severe) circle # that best describes your pain    1    2    3    4    5    6    7    8    9    10

Approximate date symptoms began or date of injury: \_\_\_\_\_

Resulting from: (check which applies)     Sports     Accident     Work Related     Involving litigation

Are symptoms: (check which applies)     constant     intermittent     worsening     improving

Check all that apply:     pain     stiffness     swelling     instability     weakness     numbness/tingling

What makes symptoms worse? \_\_\_\_\_

What makes symptoms better? \_\_\_\_\_

What previous or formal treatment have you had? (medications, therapy, surgery, injections) \_\_\_\_\_

Were previous treatments helpful to any degree? If so what? \_\_\_\_\_

**PAST SURGICAL HISTORY AND/OR HOSPITALIZATION**

Previous: Type of Operations or reason for Hospitalization	Year
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

Any previous fractures?  YES     NO    If yes, what body part? \_\_\_\_\_

Any other serious injuries?  YES     NO    If yes, what happened and when? \_\_\_\_\_

**MEDICATION INFORMATION**

Drug Allergies: Do you have any drug allergies?  YES     NO    Allergic to Latex?  YES     NO  
 If yes, name the drug and the type of reaction. (example: rash, nausea, etc.) PLEASE BE SPECIFIC. \_\_\_\_\_

**CURRENT MEDS:** (List any medications you are taking at this time. Includes such items as aspirin, vitamins, laxatives, calcium, etc.)

NAME OF DRUG	DOSE(include strength & Number of pills per day)	How long have you Taken this medication?	Please Check: Helped?		
			A lot	Some	Not At All
1)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MEDICAL HISTORY/REVIEW OF SYSTEMS**

Please check if you have had any of the following:	YES	NO		YES	NO
<b>GENERAL</b> -----	-----	-----	<b>CARDIOVASCULAR</b> -----	-----	-----
Are you currently pregnant?			Chest pain		
Diabetes			Heart attack		
Stroke			Palpitations		
Kidney disease			High blood pressure		
Ulcers			Shortness of breath		
Asthma or lung disease			Ankle swelling		
Cancer TYPE:			<b>HEMATOLOGIC</b> -----	-----	-----
Fatigue			Anemia		
Weakness			Blood clots		
Fevers			Bleeding tendency		
Skin problems/disorders TYPE:			Easily bruised		
Rheumatic fever			Circulatory problems		
Tuberculosis			Blood thinners (currently on)		
Recent weight loss/gain. How much?			(if yes, type? )	-----	-----
<b>BLOODBORNE PATHOGENS</b> -----	-----	-----	Phlebitis		
HIV/AIDS			<b>MUSCULOSKELETAL</b> -----	-----	-----
Hepatitis			Joint pain		
Other			Joint swelling		
<b>SITES OF INFECTION</b> -----	-----	-----	Muscle weakness		
Urinary			Muscle tenderness		
Dental			Morning stiffness		
Other			Arthritis/osteoarthritis		
<b>NEUROLOGICAL</b> -----	-----	-----	Rheumatoid arthritis		
Headaches			Bunions		
Dizziness			Osteoporosis		
Fainting			Previous bone density test? When?		
Memory loss			Bone/joint infections		
Loss of consciousness			Gout		
Muscle spasms			<b>PSYCHOLOGICAL</b> -----	-----	-----
Numbness or tingling of hands/feet			Depression		
Blindness or trouble seeing			Anxiety disorder		
Deafness or trouble hearing			Other		
Seizures					

Other illnesses or diseases which are not listed? Please describe. \_\_\_\_\_

**FAMILY HISTORY**

Please check if any of your family (parents, brothers, sisters, grandparents) have a history of any of the following:

	YES	NO		YES	NO
Diabetes (sugar)			Abnormal bleeding tendencies		
Heart disease			Rheumatoid arthritis		
Anesthetic complications			Osteoarthritis		
Cancer TYPE:			Gout		

**SOCIAL HISTORY**

Occupation: \_\_\_\_\_ # of years \_\_\_\_\_ Duties \_\_\_\_\_  
 Do you smoke? (check one)  YES  NO  PAST If yes or past, # of packs per day \_\_\_\_\_ years \_\_\_\_\_  
 Are you (check one)  Right handed  Left handed  Both  
 Do you consume alcohol? (check one)  YES  NO If so, how many drinks per week? \_\_\_\_ Is there a history of abuse?  YES  NO  
 Have you ever had a problem with drugs? (check one)  YES  NO  
 Do you participate in recreational drugs?(check one)  YES  NO  PAST If yes or past, list type and amount. \_\_\_\_\_  
 Do you regularly wear your seat belt? (check one)  YES  NO  
 Please list all sports and hobbies you are involved in: \_\_\_\_\_  
 What is your principle support system? Example, spouse, family, church \_\_\_\_\_  
**I as the patient, state the information is correct and accurate to the best of my knowledge.**  
 (patient signature) \_\_\_\_\_ Date \_\_\_\_\_

**I have reviewed this information with this patient.**

(M.D. signature) \_\_\_\_\_ Date \_\_\_\_\_