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| **New Patient History Form** |



Using a black or blue pen, please write clearly and answer **ALL** questions by filling out the appropriate box(es).

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| Name: | | Today’s Date: |
| Date of Birth: | Gender (circle): Male Female  Undifferentiated | Height: Weight: |
| Primary Care Provider: | | Clinic/Location: |

**Current Medications/Supplements:**

\_\_\_\_\_\_\_ By initialing, I authorize Restoration Osteopathic Medicine to obtain my medication history from community pharmacies and/or pharmacy benefit managers for the purpose of continued treatment.

☐ **I am not taking any prescribed medications or over-the-counter supplements/vitamins.**

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| **Medication** | **Dose** | **How many times per day?** |
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**Allergies:**

☐ **I have no known allergies to prescribed medications or medical supplies.**

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| --- | --- |
| **Medication** | **Reaction** |
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**Surgical History:**

Please list any previous surgeries. ☐ **NONE**

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| **Surgery** | **Date** |
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**Medical History:**

Please indicate whether you have or have had any of the following by filling in the appropriate box(es). ☐ **NONE**

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| --- | --- | --- | --- |
| **General:**  ☐ COPD  ☐ High Blood Pressure  ☐ Diabetes  ☐ Myocardial Infarction (MI)  ☐ Stroke  ☐ Arthritis  ☐ Migraine  ☐ Asthma  ☐ Heart Failure (CHF)  ☐ Irregular Heartbeat  **Allergy:**  ☐ Hay Fever  ☐ Other\_\_\_\_\_\_\_\_\_\_\_\_  **Cancer:**  ☐ Skin (BCC, SCC or MM)  ☐ Prostate  ☐ Bladder  ☐ Thyroid  ☐ Bone  ☐ Lung  ☐ Colon | **Circulatory/Cardiovascular:**  ☐ Aneurysm  ☐ DVT  ☐ Pacemaker  ☐ Atrial Fibrillation  ☐ Varicose Veins  **Dermatologic:**  ☐ Eczema  ☐ Psoriasis  **Digestive/Gastrointestinal:**  ☐ Gallbladder Disease  ☐ Liver Disease  ☐ Colitis  ☐ GERD  ☐ Hepatitis B or C (Circle)  **Ears:**  ☐ Vertigo  ☐ Hearing Problem  **Endocrine:**  ☐ Endocrine Disorder  ☐ Thyroid Disorder | **Genitourinary:**  ☐ Kidney Disease  ☐ Renal Dialysis  ☐ Kidney Infection  ☐ Renal Failure  ☐ Urinary Disorder  **Hematologic:**  ☐ Anemia  ☐ Blood Disorder  ☐ Taking Blood Thinners  **Infectious:**  ☐ Tuberculosis  ☐ Lyme Disease  ☐ HIV/AIDS  **Musculoskeletal:**  ☐ Artificial Joint  ☐ Hip Fracture  ☐ Osteoarthritis  ☐ Knee Disorder  ☐ Fracture  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_ | **Neurologic:**  ☐ Meningitis  ☐ TIA  ☐ Head Injury  ☐ Traumatic Brain Injury  ☐ Brain Disorder  ☐ Multiple Sclerosis  **Psychologic:**  ☐ Anxiety  ☐ Depression  ☐ Emotional Abuse  ☐ Physical Abuse  ☐ Attempt Suicide  ☐ Psychiatric Disorder  ☐ Schizophrenia  ☐ Sexual Abuse  **Respiratory:**  ☐ Sleep Apnea  ☐ Chronic Lung Disease  ☐ Other\_\_\_\_\_\_\_\_\_\_\_\_  ☐ Other\_\_\_\_\_\_\_\_\_\_\_\_  ☐ Other\_\_\_\_\_\_\_\_\_\_\_\_ |

**Review of Symptoms**

Please indicate whether you have or have had any of the following by filling in the appropriate box(es). ☐ **NONE**

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| --- | --- | --- | --- |
| **General:**  ☐ Fatigue  ☐ Weight Gain  ☐ Weight Loss  ☐ Weakness  **Musculoskeletal:**  ☐ Restricted motion  ☐ Muscle stiffness  ☐ Swelling  ☐ Joint Pain  ☐ Joint Stiffness | **Cardiovascular:**  ☐ Palpitations  ☐ Chest Pain  ☐ Swelling of Legs  **Gastrointestinal:**  ☐ Abdominal Pain  ☐ Nausea  ☐ Diarrhea  ☐ Heartburn | **Psychiatric:**  ☐ Anxiety  ☐ Depression  ☐ Hallucinations  ☐ Insomnia  ☐ Nervousness  **Neurological:**  ☐ Fainting  ☐ Tingling  ☐ Dizziness  ☐ Numbness | **Hematologic/Lymph:**  ☐ Easy Bruising  ☐ Easy Bleeding  ☐ Lumps  ☐ Blood Clots  **Respiratory:**  ☐ Cough  ☐ Short of Breath  ☐ Wheezing |

**Family History:**  ☐ **NONE, Family members are all healthy.**

☐ **No Known Family History**

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| --- | --- | --- |
| **Family Member** | **Disease/Disorder** | **Alive or Deceased** |
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**Social History:**

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| --- | --- |
| Occupation: |  |
| Employment Status: | ☐ Full-time ☐Part-time ☐ Retired ☐Unemployed ☐ Disabled ☐Homemaker |
|  |  |
| Exercise:  ☐ NONE | Type: Intensity: Duration: Frequency:  ☐ Flexibility ☐ Light ☐ 0-30 mins ☐ Daily  ☐ Aerobic ☐ Moderate ☐ 31-60 mins ☐ Weekly  ☐ Vigorous ☐ 1- 1.5 hrs ☐ Monthly |
| Caffeine:  ☐ NONE | Type: Cups (Daily):  ☐ Coffee ☐ Less than 1  ☐ Tea ☐ 1-2  ☐ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ 3-4 |
| Alcohol:  ☐ NONE | Type: Frequency:  ☐ Beer ☐ Social  ☐ Wine ☐ Light  ☐ Liquor ☐ Occasional |
| Smoking Status: | ☐ Current every day smoker ☐Current some day smoker ☐Light tobacco smoker  ☐Heavy tobacco smoker ☐Former ☐Never |
| Nicotine products: | ☐ Cigars ☐Pipe ☐E-Cigarette ☐Chewing Tobacco ☐Former ☐Never |
| Drug use: | ☐Current- Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐Former- Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐Never |

**Imaging:**

Please indicate if you have had any of the following imaging. ☐ **NONE**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type** | **Area of Body** | **Date** | **Facility** |
| Ultrasound |  |  |  |
| X-Ray |  |  |  |
| MRI Scan |  |  |  |

**Chief Complaint – Primary Reason for Today’s Visit:**

|  |  |  |  |
| --- | --- | --- | --- |
| Location of Pain: | | Radiates? ☐ Yes ☐ No  If so, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Date of Onset: | |
| Timing: | ☐ Continuous ☐ Intermittent  ☐ Changes in severity but always present | Started? ☐ Gradually ☐ Suddenly | |
| Cause: ☐ Accident ☐ Work Injury ☐ Surgery/Other  If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Change over time: | ☐ Improved  ☐ Worsened ☐ Stayed the Same |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Affects:**  ☐ Concentration  ☐ Work  ☐ Appetite  ☐ Sleep  ☐ Daily Activities  ☐ Recreational Activities  ☐ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Improves With:**  ☐ Sitting  ☐ Walking  ☐ Standing  ☐ Exercise  ☐ Lying Down  ☐ Heat/Ice  ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_ | **Worsens With:**  ☐ Sitting  ☐ Walking  ☐ Standing  ☐ Exercise  ☐ Lying Down  ☐ Heat/Ice  ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_ | **Time of day pain is better:**  ☐ Morning  ☐ Afternoon  ☐ Evening  ☐ Night  ☐ No specific time of day | **Time of day pain is worse:**  ☐ Morning  ☐ Afternoon  ☐ Evening  ☐ Night  ☐ No specific time of day |

**Pain Scale: Describe Your Pain:**

Please use as a reference to rate your pain level. **Pain Level:**  Please only check ones that apply.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Mild | Moderate | Severe |
| Sharp |  |  |  |
| Shooting |  |  |  |
| Cramping |  |  |  |
| Aching |  |  |  |
| Throbbing |  |  |  |
| Tender |  |  |  |
| Sore |  |  |  |
| Tingling |  |  |  |
| Numbing |  |  |  |
| Tiring |  |  |  |

|  |  |
| --- | --- |
| 0  1  2  3 | No pain.  You barely notice the pain.  You may feel some twinges of pain.  You notice the pain but can tolerate it. |
| 4  5  6 | You can ignore the pain at times.  Can’t ignore the pain but still work through.  Pain makes it hard to concentrate. |
| 7  8  9  10 | Pain distracts you and limits your sleep.  Pain is so intense you have trouble talking  Pain is so bad you can’t even sleep or talk.  Worst pain you can imagine. |

|  |
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| **Best:** |
| **Worst:** |
| **Currently:** |

**Treatments Tried:** ☐ **NONE**

|  |  |  |
| --- | --- | --- |
| **Type:** | **When/For How Long?** | **Any Relief?** |
| Physical Therapy |  |  |
| Chiropractic |  |  |
| Acupuncture |  |  |
| Injections |  |  |
| Massage |  |  |
| Medications (Example: Advil, Oxycodone, Flexeril, Prozac, Gabapentin, etc.) |  |  |