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PATIENT HISTORY

Please PRINT and fill out completely

Name:_____ Today's Date: _____

Age: _____ Height: _____ Weight: _____ Hand Dominance: □ Left □ Right

What type of work do you do (job title): _____

How did you get referred to this office:_____

Ins Co and ID#_____ **Primary Insured**_____

Secondary Insurance Name ID#_____

REASON FOR TODAY'VISIT:

HISTORY OF INJURY

Did the problem result from a specific injury? □ Yes □ No **Injury/Accident Date:** _____

Did your problems begin following: □ Work Injury? □ Motor Vehicle Accident? What State: _____

How did you get injured? _____

How long have you had the condition? _____

Please rate your pain on a scale of 0 to 10 (10 being the most painful): ____

Is the pain:□ Constant □ Occasional □ Sharp □ Dull
■ Aching □ Stabbing □ Throbbing

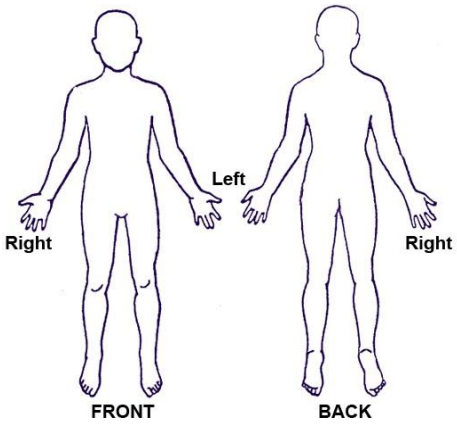
What symptoms are you experiencing? □ Swelling □ Locking
■ Catching □ Giving Way □ Popping □ Grinding □

What, if anything, makes your symptoms *better*?

_____

What, if anything, makes your symptoms *worse*?

_____



Circle the body parts where you have pain.

Have you seen another physician for this problem/injury? □ Yes □ No
If yes, who? _____

What treatments have you tried? □ Nothing □ Physical Therapy □ Exercise □ Acupuncture
■ Chiropractic □ Injections (*specify:* Cortisone, Sacroiliac, Selective Nerve Root Block, Synvisc, Hyalgan)
■ Medications_____ ■ Other _____

Have you had any of the following tests?

Test	Date (month/year)	Where were the tests done?
■ X-rays	_____	_____
■ MRI scan	_____	_____
■ CT scan	_____	_____
■ EMG/NCV	_____	_____

■ Other _____ _____

Regular Exercise: □ Yes □ No Type of exercise and activity you enjoy?

PAST SURGICAL HISTORY

Please check any previous surgical procedures. List the date and location.

■ Appendectomy _____ ■ Arthroscopy Lower Extremity _____ ■ Arthroscopy Upper Extremity _____

■ Hernia Repair _____ ■ Spine/Back Surgery _____ ■ Heart Surgery _____ ■ Fracture Repair

■ Total Joint Replacement _____ ■ Other _____

SOCIAL HISTORY

Special Diet: □ Yes □ No Any restrictions? _____
Tobacco Use: □ Yes □ No Type:_____Duration:_____Quit Date: _____
Alcohol Use: □ Yes □ No Frequency:_____
Drug Use: □ Yes □ No Frequency:_____
Caffeine Use: □ Yes □ No Frequency: _____

ALLERGIES

Are you allergic to: Penicillin: □ Yes □ No Sulfa: □ Yes □ No Latex: □ Yes □ No

■ No known drug allergies

Please all other allergies: _____

MEDICAL HISTORY

Please check *current* or *previous* medical conditions:

■ Anemia	□ Irregular Heartbeat	□ Arthritis	□ HIV
■ Asthma	□ Heart Attack	□ Rheumatoid Arthritis	□ Chemical Dependency
■ Blood Clots	□ High Blood Pressure	□ Thyroid	□ Alcoholism
■ Cancer	□ High Cholesterol	□ Liver Disease	□ Depression
■ Diabetes	□ Heart Disease	□ Stroke/Seizures	□ Hepatitis A or B
■ Emphysema	□ Osteoporosis		

■ Other _____

Have you ever had a blood transfusion? □ Yes □ No If yes, when? _____

MEDICATIONS Please list all medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin, and any other over-the-counter medications. Include vitamin, mineral, and herb supplements.

Medication	Dosage	Frequency

GASTROINTESTINAL HISTORY

Do you have a history of Peptic Ulcer Disease? □ Yes □ No If yes, when? _____
Do you have a history of GI, stomach bleed? □ Yes □ No If yes, when? _____
Do you take any medications for your stomach? (Please include over the counter medications: i.e. Pepcid,

Pain Medicine, etc.) Include dosage and frequency.

Have you ever taken anti-inflammatory medicine for a period greater than 30 days? (*Please include over the counter medications such as Advil, Aleve, and previously prescribed medications, such as Celebrex List all you have tried*.)

FAMILY HISTORY

Please check family history conditions:

■ Blood Clots □ Diabetes □ Hypertension □ Rheumatoid Arthritis
■ Cancer □ Heart Disease □ Osteoporosis □ Stroke □ Seizures

Please describe any immediate family history of medical problems:

REVIEW OF SYSTEMS

Check if you have *current symptoms or current known* medical problems in the following areas. Please describe. If you do not have any problems, please check the *None* box.

CONSTITUTIONAL □ None □ Weight Loss □ Weight Gain □ Insomnia □ Chronic Fatigue
GENERAL □ Other:

EYES □ None □ Vision Change □ Glasses/Contacts □ Cataracts □ Glaucoma
■ Other:

EARS, NOSE, THROAT □ None □ Loss of Hearing □ Seasonal Allergies □ Sinus Pain □ Ringing in Ears
□ Other:

HEART □ None □ Chest Pain □ Hypertension □ Edema □ Palpitations
■ High Cholesterol □ Other:

RESPIRATORY □ None □ Asthma □ Wheezing □ Frequent Cough
■ Other:

GI □ None □ Heartburn □ Indigestion □ Acid Reflex □ Peptic Ulcer
■ Ulcer Problems □ Abdominal Pain □ GI, Stomach Bleed
■ Other:

SKELETAL □ None □ Arthritis □ Muscle Weakness □ Joint Pain □ Back Pain
■ Other:

SKIN □ None □ Rash □ Ulcers □ Scars
■ Other:

NEUROLOGICAL □ None □ Headaches □ Numbness □ Seizures □ Dizziness
■ Other:

PSYCHIATRIC □ None □ Depression □ Mood Swings □ Anxiety □ Crying
■ Other:

ENDOCRINE □ None □ Diabetes □ Hypothyroid □ Hyperthyroid □ Hot Flashes
■ Other:

HEMATOLOGY □ None □ Easy Bruising □ Bleeding □ Anemia
■ Other:

Pharmacy Name and Location

Patient Name: _____

Signature: _____ Date: _____

Print Name: _____

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