PATIENT MEDICAL HISTORY

Patient's Name:_________________________________ **Today's Date:**____________________

Date of Birth: ________________ **Age:** ____________ **Height:**__________ **Weight:**__________

Sex :_________ **Race:**____________ **Ethnicity:**________________ **Preferred Language:**____________

Home Phone:______________ **Work Phone:**______________ **Cellular Phone:**____________________

Pharmacy:___________________________ **Pharmacy address & phone:**____________________________

CHIEF COMPLAINT

**Why are you here today? ____

____

**What Happened? ____

____

____

Are you Right or Left Handed? _____________ Date of Injury or Onset of Symptoms? ____________________

Is this injury due to one or more of the following: (please circle) Auto related Work related Slip and Fall

Other (please explain)____

Were you seen in the E.R./or by another physician? ____

Are your symptoms improving/unchanged/or worsening?____

Are you working now? __________ What is your Occupation? _________________________________

HISTORY OF PRESENT ILLNESS

Initial symptoms:

___Catching ___ Locking ___ Weakness ___ Numbness

___Initial popping sound ___Slipping ___ Pain with overhead activity ___ Tingling

___Giving way ___Stiffness ___Pain with reaching behind neck/back

___ Weight bearing: ___with pain ___with no pain ___unable to bear weight ___ Night Pain

Pain : ***PLEASE ANSWER THE FOLLOWING TO HELP YOU DESCRIBE YOUR PAIN***

Quality - *Aching* *Burning* *Diffuse* *Dull* *Knifelike* *Pounding* *Sharp* *Stabbing* *Tearing* *Throbbing*

Frequency of your Pain: Intermittent_____ Constant_____ Frequent______ Infrequent_______

Severity of your pain **at this time**:(Mild--1--2--3) (Moderate--4--5--6--7) (Intense--8--9-10) (Rate pain on a scale from 1 to 10)

Severity of your pain **at its worse**:(Mild--1--2--3) (Moderate--4--5--6--7) (Intense--8--9-10) (Rate pain on a scale from 1 to 10)

Activity Limitations: Please *check* any of the following limitations that apply or write your own personal limitation.

___Climbing stairs ___In and out of chair ___Walking ___Lifting

___In and out of car ___Kneeling ___Bending forward ___Household chores

___Working light duty ___Unable to work ___Yard work ___Getting dressed

My personal limitations: ____

What makes symptoms worse?____

What makes symptoms better?____

Therapies tried:

___Braces ___Crutches ___Cold/Heat ___Elevation ___Physical Therapy ___ Chiropractor

Medication:

___Anti-inflammatory ___Narcotics ___Steroids ___Over-the-counter ___ Injections

Any previous medical or surgical treatment for this condition? ___ Yes ___ No If yes, what:____________

____

PAST MEDICAL HISTORY

Patient's Name:________________________________ **Today's Date:**____________________

Please list your past illnesses

____
____
____
____
____

Please list your past injuries.

____
____
____
____
____

CURRENT MEDICATIONS

Medication Name	Dose	Why are you taking this medication?

ALLERGIES: (Please answer Y for yes or N/A if not applicable. **If yes,** please describe the adverse symptoms or reaction.

List medications you are allergic to:____

____

Environmental Allergies:____

Food Allergies:____

Cosmetic or personal care product Allergies:____

Plastic Allergy:____

Latex Allergy:____

PAST SURGICAL HISTORY:

Surgical Procedure	Date	Name of Surgeon

CHILDHOOD DISEASES:

Asthma_____ Chicken Pox_____ Measles _____ Mumps_____ Rheumatic fever_____ Scarlet fever____

SOCIAL HISTORY:

Marital Status: _____Married _____Single _____Divorced _____Widowed _____Separated

Tobacco use - Current Smoker: Amount and duration ____________________Former Smoker ___ Never Smoker ___

Alcohol - **Wine** - Occasional______ 2-3 times per week______ Daily______ Socially only______

Mixed drinks or Hard Liquor - Occasional______ 2-3 times per week______ Daily______ Socially only______

Beer - Occasional______ 2-3 times per week______ Daily______ Socially only______

Ancillary aids - Glasses _______ Contacts _______ Dentures _______ Hearing aids __________

Drug use - Never used Drugs______used Drugs in the past ______________Using Drugs now Socially_____________

Camping/Hunting - if yes, when & where ____

Scuba diving - if yes, state how often, how deep you dive and for how long: __________________________________

Travel outside of the country, if so ______________________ where _______________________when

FAMILY HISTORY:

Father Status _____living ____ deceased

Illness___________________________

Cause of death_______________; _____age at death

Mother Status _____living ____ deceased

Illness___________________________

Cause of death ______________: _____age at death

REVIEW OF MEDICAL SYSTEMS

Patient's Name:___________________________________ **Today's Date:**_________________

General/Constitutional:

Yes	No	
Y	N	Decreased Activity
Y	N	Change in appetite
Y	N	Fever
Y	N	Chills
Y	N	Tires easily
Y	N	Lost Weight
Y	N	Gained Weight

Eyes:

Yes	No	
Y	N	Recent vision changes
Y	N	Double Vision

Ears Nose Throat:

Y	N	Earaches
Y	N	Hearing loss
Y	N	Ear pain
Y	N	Ear Ringing
Y	N	Dizziness
Y	N	Congestion
Y	N	Nose Bleeds
Y	N	Bleeding gums
Y	N	Full Dentures
Y	N	Partial Upper Dentures
Y	N	Partial Lower Dentures
Y	N	Difficulty swallowing
Y	N	Hoarseness
Y	N	Sore throat

Respiratory:

Yes	No	
Y	N	Asthma
Y	N	Bronchitis
Y	N	Cough
Y	N	Shortness of Breath
Y	N	Bronchitis
Y	N	Coughing up blood
Y	N	Recent Respiratory Infection
Y	N	Sleep Apnea

GI:

Yes	No	
Y	N	Abdominal pain
Y	N	Nausea
Y	N	Vomiting
Y	N	Diarrhea
Y	N	Heartburn
Y	N	Indigestion

Musculoskeletal:

Yes	No	
Y	N	Joint pain
Y	N	Tenderness
Y	N	Weakness
Y	N	Swelling
Y	N	Redness
Y	N	Stiffness
Y	N	Cramping
Y	N	Loss of motion

Neurological:

Yes	No	
Y	N	Abnormality of walk
Y	N	Balance
Y	N	Blackouts
Y	N	Burning sensations
Y	N	Confusion
Y	N	Coordination
Y	N	Dizziness
Y	N	Fainting
Y	N	Headaches
Y	N	Lightheadedness
Y	N	Loss of consciousness
Y	N	Loss of sensation
Y	N	Memory loss
Y	N	Numbness
Y	N	Paralysis
Y	N	Speech difficulty
Y	N	Tingling
Y	N	Tremor
Y	N	Weakness

Skin:

Yes	No	
Y	N	Lesions
Y	N	Itching
Y	N	Discoloration
Y	N	Rash
Y	N	Ulceration

Psychiatric:

Yes	No	
Y	N	Compulsive behavior
Y	N	Mood swings

Hematologic/lymphatic:

Yes	No	
Y	N	Easy bruising
Y	N	Swollen lymph node
Y	N	History of transfusion

GU:

Yes	No	
Y	N	Pain with urination
Y	N	Blood in Urine
Y	N	Abnormal Urine test
Y	N	Frequent urination
Y	N	Kidney stones
Y	N	Prostate surgery

Females

Yes	No	
Y	N	Normal Menstruation
Y	N	Menopause
Y	N	Ovaries removed
Y	N	Birth control pills

Cardiac:

Yes	No	
Y	N	Chest pain
Y	N	Heart murmur
Y	N	Hypertension
Y	N	Abnormal EKG
Y	N	Cold hands & feet
Y	N	Palpitations
Y	N	Abnormal stress test
Y	N	Edema

updated 2/25/08