Patient Account #________________ **PATIENT MEDICAL HISTORY** Today's Date: _________________

PERSONAL

NAME: _________________________ AGE: ______ SS#: ____________ DOB: _________ WEIGHT: ____ lbs.

HEIGHT: ___ Ft ___ In Blood Pressure ____/____ SEX: ❒ **M** ❒ **F** ❒ LEFT HANDED ❒ RIGHT HANDED

RETIRED: _______ EMPLOYER: _________________________

REFERRED BY: ____________________________ PRIMARY CARE PHYSICIAN: ____________________________

HISTORY OF PRESENT ILLNESS

Please describe the problem and the symptoms that brought you here today.

____

____

Injury Date and Time: ____ ❒ No Injury

❒ Motor Vehicle Accident ❒ Work Injury ❒ Sports Injury ❒ Arthritis ❒ Other: ____________________

Where is the pain? ❒ Neck With radiation to ❒ R Arm ❒ L Arm ❒ Other
❒ Back With radiation to ❒ R Leg ❒ L Leg
❒ Shoulder ❒ L ❒ R ❒ Elbow ❒ L ❒ R ❒ Wrist ❒ L ❒ R ❒ Hand ❒ L ❒ R
❒ Hip ❒ L ❒ R ❒ Knee ❒ L ❒ R ❒ Ankle ❒ L ❒ R ❒ Foot ❒ L ❒ R

How long have you had the pain? __________ Days ___________ Months ____________Years

LEAST ➞ **MOST**

How severe is the pain? ❒0 ❒1 ❒2 ❒3 ❒4 ❒5 ❒6 ❒7 ❒8 ❒9 ❒10

What is the pain like? ❒Ache ❒Sharp ❒Dull Burn ❒Radiating ❒Other: ________________________

When does it hurt ❒ Constant ❒On and Off ❒ Other: ____

Any associated symptoms? ❒Numbness ❒Swelling ❒Stiffness ❒Other: ________________________________

Any Treatments? Medications Surgery

______________________________ ____________________________________

Physical Therapy Other

__________________________ ____________________________________

Any Tests? ❒ X-RAYS ❒CT ❒MRI ❒BONE SCAN ❒NERVE TESTS ❒BLOOD WORK

Done Where? ____

CURRENT MEDICATIONS

Pharmacy Name:_______________________ Pharmacy Phone: _______________________

Name and Dose	Name and Dose	Name and Dose
______________________________	________________________________	________________________________
______________________________	________________________________	________________________________

ALLERGIES

❒ PENICILLIN ❒ SULFA ❒ CODEINE ❒ SHELLFISH ❒ LATEX ❒ NONE ❒ OTHER ____________________

MEDICAL CONDITIONS

(CHECK ALL THAT APPLY) ❒ **NO ILLNESS**

❒ AIDS/HIV	❒ DEPRESSION	❒ MENTAL/NERVE DISORDER
❒ ALCOHOLISM	❒ DIABETES	❒ PANCREATITIS
❒ ANGINA	❒ ELEVATED CHOLESTEROL	❒ PHLEBITIS/BLOOD CLOTS
❒ ATRIAL FIBRILLATION	❒ EMPHYSEMA	❒ PNEUMONIA
❒ ARTHRITIS	❒ GALL BLADDER DISEASE	❒ SKIN DISEASE
❒ BLADDER INFECTION	❒ HEART ATTACK	❒ STROKE
❒ BLEEDING DISORDER	❒ HEPATITIS	❒ THYROID DISEASE
❒ BRONCHITIS	❒ HIGH BLOOD PRESSURE	❒ TUBERCULOSIS
❒ CANCER	❒ INTESTINAL PROBLEMS	❒ ULCERS
❒ CHEMICAL DEPENDENCY	❒ KIDNEY DISEASE	❒ OTHER: _________________

PAST MEDICAL HISTORY

PREVIOUS SURGERY ____ DATE________________
____ DATE ________________
____ DATE ________________

HOSPITALIZATIONS ____ DATE ________________
____ DATE ________________

SOCIAL HISTORY

DO YOU USE TOBACCO? ❒ CURRENT ❒ FORMER ❒ NEVER

TYPE: ❒CIGARETTES ❒ CIGARS ❒ PIPE ❒ SMOKELESS ❒ SNUFF ❒ CHEWING

________________ PACKS/DAY ____________________ YEARS

DO YOU DRINK ALCOHOL? ❒ NO ❒ YES ________________ AVERAGE WEEKLY CONSUMPTION

FEMALE PATIENTS Oral Contraception? ❒ NO ❒ YES Any chance you are pregnant? ❒ NO ❒ YES

FAMILY HISTORY

(CHECK ALL THAT APPLY) ❒ NO DISEASES

❒ CANCER
❒ DIABETES
❒ HIGH BLOOD PRESSURE
❒ HEART DISEASE
❒ ASTHMA
❒ TUBERCULOSIS
❒ KIDNEY DISEASE
❒ ARTHRITIS
❒ STROKE
❒ SEIZURES
❒ EXCESSIVE BLEEDING
❒ PROBLEM WITH ANESTHESIA

REVIEW OF SYMPTOMS (CHECK ALL THAT APPLY)

GENERAL
❒ None
❒ Fever
❒ Chills
❒ Weight Change

HEAD
❒ None
❒ Headaches
❒ Dizziness
❒ Hearing Loss
❒ Ringing in Ears
❒ Double/Blurred Vision
❒ Sore Throat/ Hoarseness
❒ Recent Cold

CHEST
❒ None
❒ Shortness of Breath
❒ Chest Pain
❒ Palpitations
❒ Wheezing
❒ Rheumatic Fever
❒ Heart Murmur

ABDOMEN
❒ None
❒ Nausea/Vomiting
❒ Difficulty Swallowing
❒ Gas/Bloating
❒ Indigestion
❒ Abdominal Pain
❒ Diarrhea
❒ Bloody Stools
❒ Hemorrhoids

URINARY
❒ None
❒ Blood in Urine
❒ Burning Sensation
❒ Bladder/Kidney Infection
❒ Frequent Urinating
❒ Incontinence

ORTHOPEDIC
❒ None
❒ Fracture/Dislocation
❒ Sprain/Strain
❒ Tendonitis
❒ Joint Stiffness
❒ Joint Pain
❒ Rheumatoid Disease
❒ Gout
❒ Swelling of Feet

SKIN
❒ None
❒ Rash/Itching
❒ Psoriasis
❒ Raynaud's
❒ Varicose Veins

EMOTIONAL
❒ None
❒ Depression
❒ Bipolar Disorder
❒ Seizure Disorder

OTHER
____
____
____
____

PATIENT NAME:____ PATIENT ACCOUNT #____________________

PATIENT SIGNATURE ____ DATE _____________