

PATIENT HISTORY FORM

Name:		Date of Birth:		Height:		Weight:							
Referred By:	<input type="checkbox"/> Physician	<input type="checkbox"/> Self	<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Insurance Company	<input type="checkbox"/> Other							
Name of Person/Physician Making Referral:													
Reason for Your Visit:	Body Part:			<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both							
	<input type="checkbox"/> Acute, New Injury			<input type="checkbox"/> Old, Chronic Injury									
Approximate date symptoms began, or date of injury? :													
Injury Resulted From: <input type="checkbox"/> Sports <input type="checkbox"/> Accident <input type="checkbox"/> Work Related <input type="checkbox"/> Other <input type="checkbox"/> Unknown													
How did your symptoms begin? If sudden, describe onset:													
Check all that apply: <input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Instability <input type="checkbox"/> Weakness <input type="checkbox"/> Numbness/Tingling													
If you have pain, 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
What previous treatment have you had for this problem? (Medications, therapy, surgery, injection, none):													
Are you: <input type="checkbox"/> Right Handed <input type="checkbox"/> Left Handed				Occupation:									
PAST SURGICAL HISTORY/AND OR HOSPITALIZATIONS:													
Type of operations or reason for hospitalization							Year						
1.													
2.													
3.													
Any previous significant injuries or fractures?				<input type="checkbox"/> No <input type="checkbox"/> Yes									
Any history of anesthetic complications?				<input type="checkbox"/> No <input type="checkbox"/> Yes									
If yes, explain:													
MEDICATION INFORMATION:													
Drug Allergies: Do you have any drug allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes													
If yes, name the drug and the type of reaction: (rash, trouble breathing, nausea, etc.)													
Current Medications: (List all meds including aspirin, vitamins, supplements, calcium, etc.)													
Name of Drug	Dose/Pills per day (E.g. 500 mg 3 times/day)			Name of Drug	Dose/Pills per day								
1.				5.									
2.				6.									
3.				7.									
4.				8.									

PATIENT HISTORY FORM

Medical History / Review of Systems			
GENERAL	✓	CARDIOVASCULAR	✓
Are you currently pregnant?		High cholesterol	
Diabetes		Heart Attack	
Reflux Disease		High Blood Pressure	
Stomach Ulcers		Stroke	
Cancer		Circulatory or Peripheral Vascular Disease	
If yes, What type of cancer?		MUSCULOSKELETAL	
Thyroid Problems		Rheumatoid or Inflammatory Arthritis	
Psoriasis		Osteoarthritis	
HIV/AIDS		Osteoporosis	
Hepatitis		Gout	
Tuberculosis		Bone/Joint Infections	
Blood Clots		Fractures or Dislocations	
Seizure Disorders		Stress Fractures	
Concussions		Ligament, Tendon or Joint Injury	
Dental Infections		PSYCHOLOGICAL	
Urinary Tract Infections		Depression	
Kidney Stones		Anxiety Disorder	
Prostate Enlargement		Eating Disorders	

Are you currently experiencing any of the following symptoms?

Fever, night sweats or chills		Wheezing		Skin changes, rash	
Unexpected weight loss		Nausea or vomiting		Unsteady gait	
Blurred vision or ringing in ears		Diarrhea or Constipation		Dizziness	
Headaches		Difficult urinating		Tremors	
Difficulty swallowing		Change in bowel habits		Nervousness	
Chest Pain or Palpitations		Blood in urine or stool		Heat / cold intolerance	
Shortness of breath		Swelling of multiple joints		Easy bleeding or bruising	

FAMILY HISTORY

Please indicate which family members (Mother, Father, Sibling, Grandparent) if any have a history of the following conditions:

Diabetes	Abnormal Bleeding Tendencies	
Cancer Type:	Rheumatoid arthritis	
Heart Disease	History of Anesthetic Complications	

Social History

Do you smoke?	No Yes Past	How much do (or did) you smoke?
Do you drink alcohol?	How many drinks per week?	Any history of substance abuse?
List all regular activities you are involved in: (e.g., jogging, basketball, weightlifting, yoga, etc.)		
1.	3.	5.
2.	4.	6.
<i>I, as the patient, state the information is correct and accurate to the best of my knowledge:</i>		
Signature :		Date: