

PATIENT HEALTH HISTORY



NAME: _____ DOB: _____ AGE: ___ WEIGHT: ___ HEIGHT: ___

GENDER: _____ RACE: _____ PREFERRED LANGUAGE: _____

ETHNICITY: Hispanic? Yes No

ARE YOU: Right handed Left handed OCCUPATION: _____

PRIMARY CARE PHYSICIAN: _____ LOCATION: _____

CHIEF COMPLAINT

Reason for today's visit: _____

What makes it feel worse: _____

What makes it feel better: _____

Today, how painful is it on a scale of 1-10, with 10 being the worst: _____

What is it keeping you from being able to do? _____

Is this a worker's compensation injury? Yes No

Who referred you to us? _____ Location: _____

Have you been a patient in our office before? Yes No For what: _____

Is this the result of a: Injury Car accident Workplace injury Not an Injury

Date of Onset _____

Are you currently working? Full duty Partial Duty No Is this claim in litigation: Yes No

Have you consulted other health care providers (ie: doctors, physical therapists, chiropractors, etc.) for this problem? Yes (please list below) No

Provider: _____ Treatment: _____ Approx Date: _____

Provider: _____ Treatment: _____ Approx Date: _____

PAST MEDICAL HISTORY Do you have, have you had, do you take medications for?

Anxiety	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart attack	<input type="checkbox"/> Y <input type="checkbox"/> N	Psoriasis	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	High cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatoid arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N	Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N
Blood clots /DVT /PE	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Sleep apnea	<input type="checkbox"/> Y <input type="checkbox"/> N
Bowel disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Liver disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer - Type:	<input type="checkbox"/> Y <input type="checkbox"/> N	MRSA infection	<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Depression	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteoporosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis (TB)	<input type="checkbox"/> Y <input type="checkbox"/> N
Gout	<input type="checkbox"/> Y <input type="checkbox"/> N	Pregnant (currently)	<input type="checkbox"/> Y <input type="checkbox"/> N	Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N

PAST SURGICAL HISTORY History of anesthesia problems? Yes No

Procedure	Date	Surgeon

*** Please fill out reverse side of form ***

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MEDICATION LIST (include prescriptions, herbals, and over the counter medications)

Medication	Strength (dosage)	Times per Day	Disease Being Treated

ALLERGIES

Yes (see below) No known drug allergies

Medication You are Allergic To	Reaction

FAMILY HISTORY Do any immediate family members have or have had?

Anesthesia problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteoarthritis	<input type="checkbox"/> Y <input type="checkbox"/> N
Blood clots or pulmonary embolism	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteoporosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer Type:	<input type="checkbox"/> Y <input type="checkbox"/> N	MRSA infection	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatoid arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N

SOCIAL HISTORY

Do you drink alcohol: Yes No If yes, how many drinks per day? _____

Do you use tobacco: Yes No What type? _____ How much? _____ For how many years? _____

Sports, hobbies, or interests? _____

What is your living situation? Alone Spouse/family Friends Nursing home/assisted living

REVIEW OF SYSTEMS Do you have? (Answer yes or no for each)

Fevers, chills	<input type="checkbox"/> Y <input type="checkbox"/> N	Cough	<input type="checkbox"/> Y <input type="checkbox"/> N	Balance issues	<input type="checkbox"/> Y <input type="checkbox"/> N
Night sweats	<input type="checkbox"/> Y <input type="checkbox"/> N	Nausea	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg numbness/tingling	<input type="checkbox"/> Y <input type="checkbox"/> N
Weight loss	<input type="checkbox"/> Y <input type="checkbox"/> N	Vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N	Arm numbness/tingling	<input type="checkbox"/> Y <input type="checkbox"/> N
Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Abdominal pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive thirst	<input type="checkbox"/> Y <input type="checkbox"/> N
Dizziness	<input type="checkbox"/> Y <input type="checkbox"/> N	Heartburn/Reflux	<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety	<input type="checkbox"/> Y <input type="checkbox"/> N
Chest pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Urinary changes	<input type="checkbox"/> Y <input type="checkbox"/> N	Depression	<input type="checkbox"/> Y <input type="checkbox"/> N
Shortness of breath	<input type="checkbox"/> Y <input type="checkbox"/> N	Rash	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive bruising	<input type="checkbox"/> Y <input type="checkbox"/> N

Patient Signature: _____ Guardian (if under 18): _____ Date: _____