PATIENT HISTORY FORM

Today's Date: _____

NOTE: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released without your authorization.

NAME_____ **DATE of BIRTH** _____/_____/_____ **FAMILY DOCTOR**_____

Occupation:_____ **Employer:**_____ **Is this Workers Compensation?** Yes No

Were you referred to us by another healthcare professional? (If yes, please state name)_____

HISTORY of PRESENT ILLNESS/CONDITION

What is the main reason for your visit today?
Circle one: Right Left Both
Body part:_____

Date of Injury *or* How long have your symptoms been present?_____

If injured, how did it occur?_____
_____

Did your symptoms start: GRADUALLY SUDDENLY

Are your symptoms: CONSTANT INTERMITTENT

How severe are your symptoms?
1 2 3 4 5 6 7 8 9 10
Mild Severe

Are you experiencing: (circle all that apply)
Pain Weakness Instability

What makes your symptoms better?
(circle all that apply)
Rest Medication Ice/heat Not Present

Any changes in appearance of affected body part:
(circle all that apply)
Deformity Redness/Rash Swelling Bruising

Have you noticed any associated symptoms?
(in other joints, etc):
_____
_____

Are you currently experiencing any of the following?
(Check all that apply)

___Fever
___Chills
___Headaches
___Recent Head Injury
___Neck Pain
___Neck Tenderness
___Chest Pain
___Shortness of Breath
___Cough
___Nausea
___Rash
___Muscular Weakness
___Tingling /Numbness
___Loss of Balance
___Joint Swelling
___Easy Bleeding
___Easy Bruising

___I am experiencing **NONE** of the above

PAST MEDICAL & SOCIAL HISTORY

List all <u>YOUR</u> chronic illnesses/conditions:
(Ex: diabetes, heart disease, high blood pressure, etc)
_____
_____
_____

List *<u>FAMILY HISTORY</u>* **of chronic illnesses/conditions:**
(Ex: Osteoarthritis, cancer, diabetes, blood clots, heart disease, etc)
<u>AND Family Relationship</u> (mother, brother, uncle, etc)
_____
_____
_____

List any past surgeries *<u>and</u>* dates:
_____
_____
_____

Are you taking any medications and/or supplements? Y N
If yes, please list all, including any non-prescription medications.
_____
_____
_____
_____
_____

What are you *<u>ALLERGIC</u>* to? (medications, metals, latex, food, etc)
*Please list all allergies*_____
_____

Do you smoke? Never Current Former
If yes, how much? _____

Do you drink alcohol? *(Circle one)*
Never Occasional Regularly Frequent

Office use only

Age _____Temp_____ Weight_____ Height_____