Patient History

Date:_____

Patient: Name: **DOB:** **AGE:**

Occupation: **SEX:** **M** **F**

Doctor(s) who sent you: **Dominant Hand:** **Rt** **Lt**

(cc) Reason for Visit:

DETAILS OF INJURY: WHERE, WHEN AND HOW INJURY OCCURRED.

Date Of Injury **If not injury, give Date of Onset**

Was Injury or onset related to: **Work: Yes** **No** **Auto Accident: Yes** **No**

Other (school, sports, activity or explain)

How did injury or onset occur?

What body parts were injured?

Any previous treatment of this problem? (Include any medications prescribed)

Is this injury potentially going to be in litigation: **Yes** **No**

Name of Physician (s) who treated you: **When?**

History Of Present Illness

A) LOCATION OF YOUR PAIN?

(e.g. Low Back, Neck, groin, buttock, right or left knee, calf, right or left shoulder, right or left elbow, wrist, foot pain, heel, other)

B) SEVERITY OF YOUR PAIN?

Mark the point on the line between 0 (least) 10 (worst) wich best describes how severe current pain is.

0 1 2 3 4 5 6 7 8 9 10

C) Character of the pain? (e.g. Dull, Sharp, Achy, Burning, Throbbing, Cramping, Dull, Shooting, Incapacitating, Prickly, Stabbing, Other)

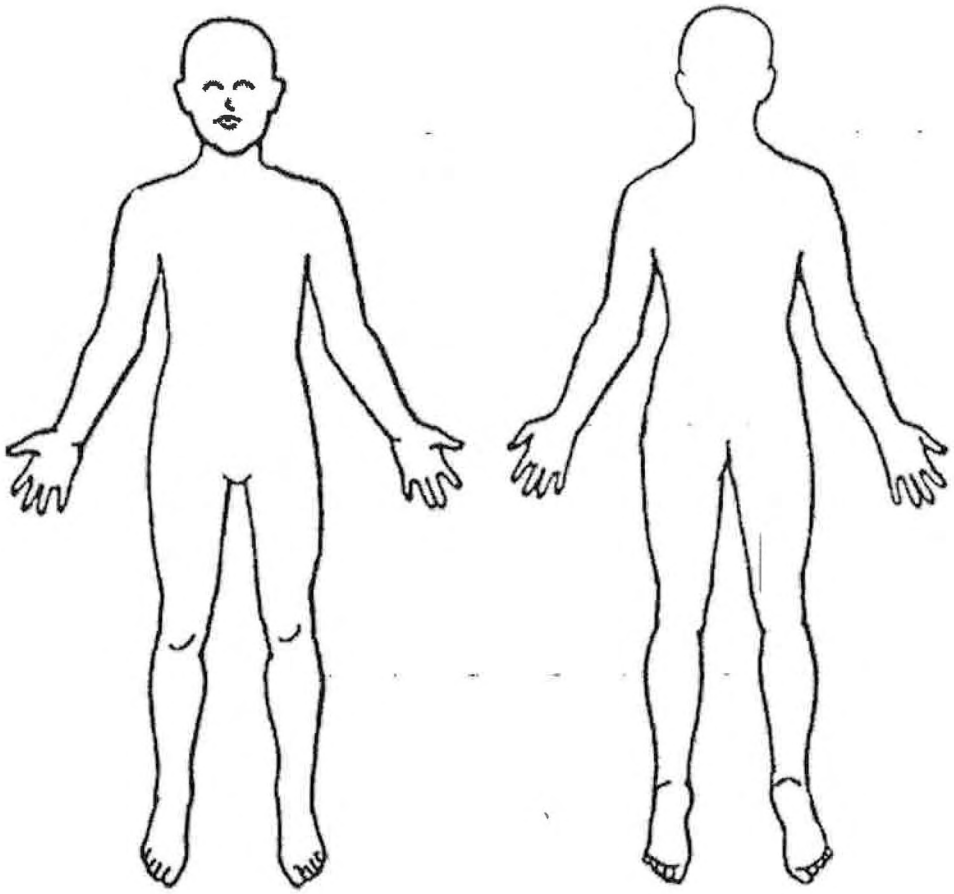
D) When do you feel pain and how long does it last?

(Morning, Afternoon, Evening, Increases over the day, Bending, Climbing, Squatting, Is the pain Constant? How long does the pain last?)

E) Associated Symptoms? (e.g. Swelling? Locking Giving Way, Tenderness, Fatigue, Bruising, Tingling, Numbness, Radiating Pain, Describe Where?)

F) What makes your symptoms better? (e.g. Rest, Heat, Cold, Elevated, Physical Therapy, Braces, Injections, Special Positioning, Medications)

Place X's at the location (s) of your worst pain using diagram below.



Patient Statement: **To the best of knowledge, the above information is accurate and complete.**

Signed:_____ **Date:** _____

Physician Signature:_____ **Date:** _____

Past Hospitalizations / Surgeries / Injuries and Approximate Dates: ( ) **Date:**

Current Medical History Please circle Yes or No if you have any of the following medial problems?

High Blood Pressure	**Y**	**N**	**Diabetes**	**Y**	**N**	**Heart Trouble**	**Y**	**N**
Respiratory Problems	**Y**	**N**	**Stroke**	**Y**	**N**	**Cancer**	**Y**	**N**
Bleeding Problems	**Y**	**N**	**HIV/AIDS**	**Y**	**N**	**Other Problems**		
Pulmonary	**Y**	**N**	**Blood Clot**	**Y**	**N**			
Gastrointestinal	**Y**	**N**	**Other**					

Current Medications: **NONE ( )**

Medication Name:	**Dosage**	**Frequency**

Allergies: ( ) None ( ) Contrast/Dye ( ) Sulfa ( ) Penicillin ( ) Local Anesthetics ( ) Latex ( ) Iodine ( ) Shellfish
Other:

Family History: ***Please list any FAMILY history medical problems ,(heart Disease, Stroke, Diabetis, Cancer)***

Father: **Mother:**
Siblings: **Other:**

Social History:

Marital Status:	**Single**	**Married**	**Separated**	**Widowed**	**Divorced**	**Partner**
Tabacco Use:	**Never**	**Packs/Day**	**How Many Years?**		**Quit/When**	
Alcohol Use:	**Never**	**Rarely**	**Moderate**	**Daily**	**How Much?**	
Drug Use: (Prescription & Non Prescription) Never		**Type & Frequency**		**Recovery Program? Y N**	**When?**	

Highest level of education: ( ) High School ( ) College ( ) Trade School ( ) Graduate School ( ) Professional School

REVIEW OF SYSTEMS (ROS) *Please circle Yes or No if you have any of the following problem?*

Constitutional			**Ears/Nose/Mouth/Throat**			**Eyes**		
Good General Health	**N**	**Y**	**Hearing loss/ringing**	**N**	**Y**	**Wear glasses / contacts**	**N**	**Y**
Recent Weight Change	**N**	**Y**	**Sinus Problems**	**N**	**Y**	**Blurred/double vision**	**N**	**Y**
Night Sweats, Fevers	**N**	**Y**	**Nose Bleeds**	**N**	**Y**	**Eye disease or injury**	**N**	**Y**
Fatigue	**N**	**Y**	**Sore Throat/voice change**	**N**	**Y**	**Glaucoma**	**N**	**Y**
Cardiovascular			**Respiratory**			**Gastrointestinal**		
Chest pain	**N**	**Y**	**Shortness of breath**	**N**	**Y**	**Nausea/vomiting**	**N**	**Y**
Palpitations	**N**	**Y**	**Cough**	**N**	**Y**	**Abdominal Pain**	**N**	**Y**
Heart Trouble	**N**	**Y**	**Wheezing/Asthma**	**N**	**Y**	**Rectal bleeding**	**N**	**Y**
Swelling hands/feet	**N**	**Y**	**Coughing up Blood**	**N**	**Y**	**Bowel Problems**	**N**	**Y**
Musculoskeletal			**Neurological**			**Integumentary (skin/breast)**		
Muscle pain or cramps	**N**	**Y**	**Frequent headaches**	**N**	**Y**	**Change in hair or nails**	**N**	**Y**
Stiffness/swelling joints	**N**	**Y**	**Paralysis**	**N**	**Y**	**Rashes or itching**	**N**	**Y**
Joint pain	**N**	**Y**	**Convulsion seizures**	**N**	**Y**	**Breast lump**	**N**	**Y**
Trouble walking	**N**	**Y**	**Numbness/tingling**	**N**	**Y**	**Breast pain or discharge**	**N**	**Y**
Endocrine			**Hematologic/Lympathic**			**Allergic /Immunologic**		
Excessive thrist/urination	**N**	**Y**	**Bruise easily**	**N**	**Y**	**Food Allergies**	**N**	**Y**
Thyroid disease	**N**	**Y**	**Slow to heal**	**N**	**Y**	**Aspirin Allergies**	**N**	**Y**
Hormone Problem	**N**	**Y**	**Enlarged glands**	**N**	**Y**	**Antibiotic Allergies**	**N**	**Y**
Genitourinary-Male Only			**Genitourinary-Female Only**			**Psychiatric**		
Blood in urine	**N**	**Y**	**Blood in urine**	**N**	**Y**	**Insomnia**	**N**	**Y**
Kidney Stone	**N**	**Y**	**Kidney Stone**	**N**	**Y**	**Confusion/memory loss**	**N**	**Y**
Sexual problems	**N**	**Y**	**Sexual problems**	**N**	**Y**	**Depression**	**N**	**Y**
Testicular	**N**	**Y**	**Menstrual problems**	**N**	**Y**			