Name:
DOB:
Chart:
Age/Gender:
Date:

Please fill out completely

Patient Medical History

How where you referred to us? _____ **Who is your primary care physician?** _____

Hand Dominance: ☐ Right ☐ Left **Occupation:** _____ **Height:** ft in **Weight:** lbs

Do you have any hobbies or play sports? _____

Body Part Affected: What Hurts? ☐ Right ☐ Left

When did this start?_____ **What do you feel?** ☐ Pain ☐ Numbness ☐ Weakness ☐ Stiffness
☐ Popping/Grinding ☐ Swelling ☐ Unstable ☐ Other

Where did the injury/symptoms occur? ☐ at home ☐ at work ☐ during sports/recreational ☐ car accident ☐ at school
☐ other _____

How did the Injury/symptoms occur? ☐ sudden/traumatic ☐ lifting/bending ☐ gradual onset ☐ injury relating to a fall
☐ recurrence of previous injury ☐ other

Allergies: ☐ No known allergies

		Reaction			Reaction
Latex	☐		Eggs	☐	
Penicillin	☐		Shellfish	☐	
Sulfa	☐		Radiological Dyes	☐	
Iodione	☐				
Soy	☐		Other		

Review of Systems: Do you currently have the following?
(Check all that apply)

Fevers	☐ No	☐ Yes		**Stomach pain**	☐ No	☐ Yes	
Vision changes	☐ No	☐ Yes		**Urination problems**	☐ No	☐ Yes	
Hearing changes	☐ No	☐ Yes		**Mole changes**	☐ No	☐ Yes	
Chest Pain	☐ No	☐ Yes		**Weight loss/gain**	☐ No	☐ Yes	
Shortness of breath	☐ No	☐ Yes		**Easy bleeding**	☐ No	☐ Yes	
				Pregnant	☐ No	☐ Yes	

Medical History:
☐ None
☐ Heart Disease
☐ Stroke/TIA
☐ Hypertension
☐ Diabetes
☐ Arthritis
☐ Other _____

Surgical History: ☐ NONE

Procedure	Year Done

Current Medications: ☐ None ☐ See Attached
Please list all meds. Continue on reverse if needed

Medication	Dose Strength

Family History: ☐ Unknown ☐ Adopted **Disease/Illness**

Mother	☐ None	☐ Deceased	
Father	☐ None	☐ Deceased	
Brother(s)	☐ None	☐ Deceased	
Sister(s)	☐ None	☐ Deceased	
Maternal Grandparents	☐ None	☐ Deceased	
Paternal Grandparents	☐ None	☐ Deceased	
Other			

Did you have complications from anesthesia? ☐ No ☐ Yes (If yes, please explain)

Social History:
Did you smoke? ☐ No ☐ Yes Quit date_____ How long did you smoke?_____ yrs Amount_____ packs/day
Do you smoke? ☐ No ☐ Yes ☐ Cigarettes _____ packs/day ☐ Cigars _____ per day ☐ Pipe _____ per day
Do you chew tobacco? ☐ No ☐ Yes
Do you use recreational drugs? ☐ No ☐ Yes Type_____ Quit Date_____
Do you drink alcoholic beverages? ☐ No ☐ Yes Abuse? ☐ No ☐ Yes Quit Date_____
If yes, how often? ☐ Socially ☐ Rarely ☐ Daily drinks/day ☐ Weekly