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

Please fill out completely

Patient Medical History

Patient Name: ______ Date: ______
Age: ______ Height: ______ Weight: ______
☐ Right handed ☐ Left handed
Occupation: ______

Chief Complaint: ☐ Pain ☐ Numbness ☐ Weakness ☐ Stiffness ☐ Swelling ☐ Popping/Grinding ☐ Unstable
☐ Other ______
Body Part Affected: ☐ Right ☐ Left ______

Date of Injury or onset of symptoms: ______
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 ☐ Latex ☐ Soy ☐ Eggs ☐ Penicillin ☐ Sulfa ☐ Iodine ☐ Shellfish ☐ Radiological dyes
☐ Other ______

Current Medications: ☐ None ☐ See Below
List prescription and non-prescription medications, including vitamins, herbal and nutritional supplements.

Medication	Dose	How Often	Medication	Dose	How Often

Review of Systems: (Check all that apply)

General: ☐ NONE ☐ Excessive fatigue ☐ Weakness ☐ Fever ☐ Exercise intolerance ☐ Other
Eye Problems: ☐ NONE ☐ Blurred vision ☐ Double vision ☐ Cataracts ☐ Glaucoma ☐ Light sensitivity
☐ Glasses/Contacts ☐ Other ______
Ears, Nose, Throat, Mouth: ☐ NONE ☐ Difficulty swallowing ☐ Nose bleeds ☐ Sore throat ☐ Ear pain ☐ Seasonal allergies
☐ Hard of hearing ☐ Other ______
Cardiovascular: ☐ NONE ☐ High blood pressure ☐ Heart attack ☐ Chest pain ☐ Palpitations ☐ Blood clots
☐ Murmur ☐ Other ______
Respiratory: ☐ NONE ☐ Shortness of breath ☐ Asthma ☐ Sleep apnea ☐ chronic cough ☐ wheezing
☐ Other ______
Stomach/Intestinal: ☐ NONE ☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Abdominal pain ☐ Gallbladder problems
☐ Other ______
Kidney/Bladder: ☐ NONE ☐ Painful urination ☐ Frequent urination ☐ Incontinence ☐ Frequent bladder infection
☐ Enlarged prostate ☐ Other ______
Musculoskeletal: ☐ NONE ☐ Muscle cramps ☐ Joint stiffness ☐ Joint pain ☐ Joint swelling ☐ Other ______
Skin Problems: ☐ NONE ☐ Itching ☐ Excessive dryness ☐ Hives ☐ Dermatitis ☐ Other ______
Neuro/Psychological: ☐ NONE ☐ Anxiety ☐ Depression ☐ Headaches ☐ Memory loss ☐ Seizures ☐ ADD/ADHD
☐ Other ______
Endocrine Problems: ☐ NONE ☐ Weight gain ☐ Weight loss ☐ Diabetes ☐ Thyroid problems ☐ Gout ☐ Liver problems
☐ Other ______
Hematologic: ☐ NONE ☐ Bruise easily ☐ Prolonged bleeding ☐ Anemia ☐ Other ______
Reproductive: ☐ NONE ☐ Pelvic pain ☐ Heavy Bleeding ☐ Cysts ☐ Other ______
If female, are you pregnant? ☐ Yes ☐ No Date of last menstrual period: ______

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

Medical History: ☐ NONE ☐ Heart Attack ☐ Stroke/TIA ☐ Cancer (What type?) ______
☐ Diabetes ☐ Arthritis ☐ Hypertension

Please list other illnesses we should know about: ______

Have you had surgery in the past? ☐ No ☐ Yes (If yes, please list - include date) ______

Have you had anesthesia in the past? ☐ No ☐ Yes

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

Do you or have you had any infectious diseases? ☐ NONE

☐ HIV/AIDS ☐ Hepatitis (Type) ______ ☐ Tuberculosis (When?) ______ ☐ Sexually Transmitted Diseases

☐ Other ______

Family History:

Family Member:	**Alive/Deceased:**	**Age(s):**	**Medical Issues (i.e. Diabetes, Cancer, High Blood pressure):**
Mother			
Father			
Biological Children How many:			
Siblings How many:			
Extended Family (Grandparents, Aunts, Uncles, Cousins)			

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Social History:

Do you smoke? ☐ Yes ☐ No ☐ Cigarettes _____ packs/day ☐ Cigars _____ per day ☐ Pipe _____ per day

Did you smoke in the past? ☐ Yes ☐ No How much? ______ When did you quit? ______

Do you chew tobacco? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, how often? ☐ Socially ☐ Rarely ☐ Daily _____ drinks/day ☐ Weekly _____ drinks/week

Do you need an interpreter: ☐ Yes ☐ No

To my knowledge, all of the above information is correct:

______ Date: ______

Patient Signature