

PATIENT HISTORY FORM (Please Print)

Patient Name: _____ Date of Birth: _____

VISIT INFORMATION

Chief Complaint: _____ Body Part: _____ Date Started: _____

Describe how the problem started and its course: _____

Doctor or person who referred you for this problem: _____

Have you been treated for this problem? Yes No If yes, by whom? _____

Is this related to a motor vehicle accident? Yes No Is this a personal injury? Yes No

*If yes to either, who is responsible? _____

Is this a work-related injury? Yes No Is an attorney involved? Yes No *If yes, name: _____

Employer: _____ Work Phone _____

Occupation: _____ Shoe Size _____ Right-handed Left-handed

Duties: _____

TREATMENT you have done for this problem X-rays, MRI, CT Scans, Bone Scans, EMGs, EKGs, Injections, Medications, Therapy, etc.

Name of Test	Body Part Tested	Date of Test	Where Was the Test Done?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Tobacco Use

Current smoker? Yes No How many packs daily? _____ How many years? _____

Former smoker? Yes No Quit date? _____

Smokeless tobacco? Current user Former user Never used

Alcohol Use

Do you drink alcohol? Yes No Less than 1 drink daily 1-2 drinks daily 3 or more daily

Fall Risk

Have you fallen in the past year? Yes No If yes: Once More than once?

Did the fall result in injury? Yes No

Do you have an Advanced Healthcare Directive? Yes No **If yes,** is it a Power of Attorney or Living Will
(Legal instructions for your medical care if you are unable to make decisions.)

ALLERGIES

Are you allergic to any drugs, medications, latex, nickel, etc? Yes No

List Allergy and Reaction(s) (i.e., hives, skin rash, itching, shock, shortness of breath, fever, etc.)

1) _____

2) _____

3) _____

4) _____

MEDICATIONS (THIS SECTION MUST BE COMPLETED)

List all prescription drugs, over-the-counter medicines, herbal remedies, inhalers, birth control pills, diet pills, blood thinners (Coumadin, Warfarin, Lovenox, Plavix, Aspirin, etc.)

<u>Name of Medication(s)</u>	<u>Dosage</u>	<u>Frequency of use</u>
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____
7) _____	_____	_____
8) _____	_____	_____
9) _____	_____	_____
10) _____	_____	_____

PHARMACY:

Name of Pharmacy you would like us to use for medications: _____

Address: _____ Phone: _____

BONE, JOINT, MUSCLE and OTHER PROBLEMS *check all that apply

- | | | |
|--|---|---|
| <input type="checkbox"/> Bone or Joint Infection | <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Other _____ | | |

SURGICAL HISTORY *Check all that apply

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Ankle Fracture Surgery | <input type="checkbox"/> Humerus Fracture Surgery | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Arthroscopic Knee Surgery | <input type="checkbox"/> Knee Replacement | _____ |
| <input type="checkbox"/> Arthroscopic Shoulder Surgery | <input type="checkbox"/> Laminectomy | _____ |
| <input type="checkbox"/> Carpal Tunnel Release | <input type="checkbox"/> Shoulder Replacement | _____ |
| <input type="checkbox"/> Elbow Fracture Surgery | <input type="checkbox"/> Spinal Fusion | _____ |
| <input type="checkbox"/> Femur Fracture Surgery | <input type="checkbox"/> Wrist Fracture Surgery | _____ |
| <input type="checkbox"/> Hip Replacement | | _____ |

MEDICAL HISTORY *Check all that apply

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Peripheral Arterial Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer – Type: _____ | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Restricted Diet: _____ |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Metal Allergy | <input type="checkbox"/> Other: _____ |

Vital Signs: (For employee use only) Temp: _____ Height: _____ Weight: _____