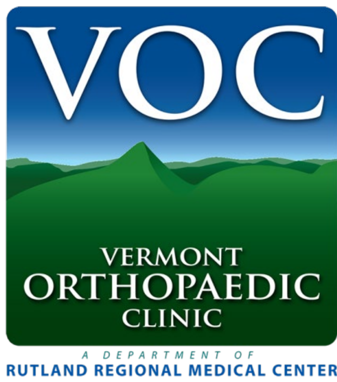

PATIENT HEALTH HISTORY

Name: ____ ❒ Male ❒ Female

DOB: _____________ Age: ______ Height: _________ Weight: _______

Occupation: ________________________ Pharmacy: ________________

Primary Care Provider: _________________ Location: _________________

Referring Provider: ____________________ Location: ________________

Reason for today's visit: ____ ❒ Left ❒ Right

Is this the result of a: ❒ Injury ❒ Car accident ❒ Workplace injury ❒ Not an injury

Date of onset: _____________ Date of injury: _____________

Briefly describe how the injury occurred: ____

What makes it feel worse: ____

What makes it feel better: ____

What is it keeping you from being able to do? ______________________________________

Describe your pain: ❒ achy ❒ sharp ❒ burning

Any related symptoms? ❒ pain ❒ swelling ❒ bruising ❒ numbness

Current pain level (1-10, 10 being the worst): ____ Pain at its worst: ____ Pain at rest: ____ Pain with activity: ____

Have you consulted with other health care providers (doctors, physical therapists, chiropractors, etc.) for this problem?

❒ Yes ❒ No If yes, please list below:

Provider: _________________ Treatment: ____________________________ Approximate date: ________

Do you not feel safe at home? ❒ Yes

REVIEW OF SYSTEMS: Check all that Apply

If yes to any of the following, is your primary care physician/provider aware of your symptoms? ❒ Yes ❒ No
(Please note that if your primary care physician/provider is not aware of any of these symptoms that you should notify him/her.)

Abdominal pain	❒	Dizziness	❒	Nausea	❒
Anxiety	❒	Excessive bruising	❒	Night sweats	❒
Arm numbness/tingling	❒	Excessive thirst	❒	Rash	❒
Balance issues	❒	Fevers, chills	❒	Shortness of breath	❒
Chest pain	❒	Headaches	❒	Urinary changes	❒
Cough	❒	Heartburn/reflux	❒	Vomiting	❒
Depression	❒	Leg numbness/tingling	❒	Weight loss	❒

PAST MEDICAL HISTORY: Check all that Apply or ❒ I have none of these below.

Do you have, have you had, and/or do you take medications for:

Anxiety	❒	Heart attack	❒	Psoriasis	❒
Asthma	❒	High cholesterol	❒	Rheumatoid arthritis	❒
Diabetes	❒	Hypertension	❒	Seizures	❒
Blood clots/DVT/PE	❒	Kidney disease	❒	Sleep apnea	❒
Bowel disease	❒	Liver disease	❒	Stroke	❒
Cancer – type:	❒	MRSA infection	❒	Thyroid disease	❒

Patient Label

PATIENT HEALTH HISTORY

Depression	❒	Osteoporosis	❒	Tuberculosis (TB)	❒
Gout	❒	Pregnant (currently)	❒	Ulcers	❒

PAST SURGICAL HISTORY **History of anesthesia problems? ❒ Yes ❒ No**

Procedure:	Date:	Surgeon:

MEDICATION LIST **(include prescriptions, herbals, and over-the-counter medications)**

Medication:	Strength (dosage):	Times per day:

ALLERGIES **❒ Yes (see below)** **❒ No Known Drug Allergies**

Medication You Are Allergic To:	Reaction:

FAMILY HISTORY ***Do any family members have or have had the following (specify Mom, Dad, Brother, Sister)?***

Anesthesia problems	❒ ________________	Diabetes	❒ ________________
Blood clots or pulmonary embolus	❒ ________________	Osteoarthritis or rheumatoid arthritis	❒ ________________
Cancer – type:	❒ ________________ ________________	Osteoporosis	❒ ________________
		MRSA infection	❒ ________________
		Heart attack	❒ ________________

SOCIAL HISTORY

Do you drink alcohol?	❒ Yes ❒ No	If yes, how many drinks per day?		
Do you use tobacco?	❒ Yes ❒ No	What type?	How much?	For how many years?
Sports, hobbies, interests:				
What is your living situation?	❒ Alone ❒ Spouse/Family ❒ Friends ❒ Nursing Home/Assisted Living			

Date/Time: ____________________ Patient/Guardian Signature: ____