

**PATIENT MEDICAL HISTORY**

**I-PERSONAL**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

WEIGHT: \_\_\_\_\_ LBS HEIGHT: \_\_\_\_\_ SEX  M  F  RIGHT HANDED  LEFT HANDED

OCCUPATION: \_\_\_\_\_ RETIRED FROM \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

**II-HISTORY OF PRESENT ILLNESS**

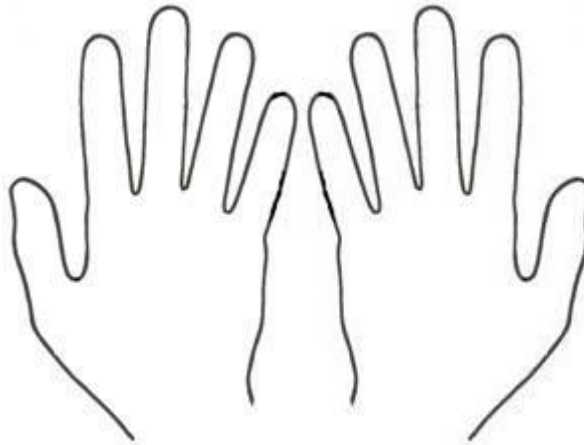
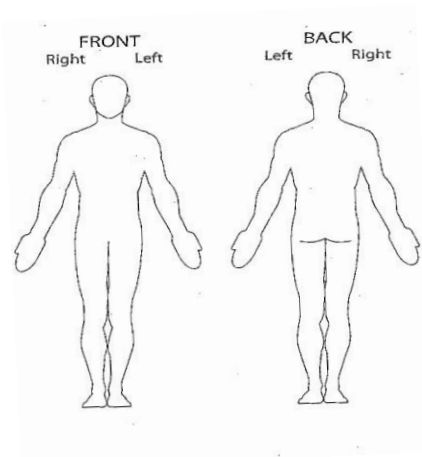
Please describe the problem and the symptoms that brought you here today.

INJURY DATE AND TIME: \_\_\_\_\_  MOTOR VEHICLE  WORK INJURY  SPORTS INJURY  ARTHRITIS  
OTHER: \_\_\_\_\_

HOW LONG HAVE YOU HAD THE PROBLEM? \_\_\_\_\_ DAYS \_\_\_\_\_ MONTHS \_\_\_\_\_ YEARS

WHERE IS THE PAIN?  NECK WITH RADIATION TO  RIGHT ARM  LEFT ARM OTHER  
 BACK WITH RADIATION TO  RIGHT LEG  LEFT LEG  
 SHOULDER  L  R  ELBOW  L  R  WRIST  L  R  HAND  L  R  
 HIP  L  R  KNEE  L  R  ANKLE  L  R  FOOT  L  R

LEAST  MOST HOW SEVERE IS THE PAIN? 0 1 2 3 4 5 6 7 8 9



Please mark the area/areas of pain.

WHAT IS THE PAIN LIKE?  ACHE  SHARP  DULL BURN  RADIATING  OTHER \_\_\_\_\_

WHEN DOES IT HURT?  CONSTANT  ON AND OFF  OTHER \_\_\_\_\_

ANY ASSOCIATED SYMPTOMS?  NUMBNESS  SWELLING  STIFFNESS  OTHER \_\_\_\_\_

WERE THERE ANY TREATMENTS FOR THIS?

MEDICATIONS \_\_\_\_\_ SURGERY \_\_\_\_\_

PHYSICAL THERAPY \_\_\_\_\_ OTHER \_\_\_\_\_

WERE ANY TESTS DONE TO ASSESS THIS PROBLEM?  X-RAYS  CT  MRI  BONE SCAN  NERVE TESTS  BLOOD WORK

**III-CURRENT MEDICATIONS**

**IF YOU HAVE A LIST OF MEDICATIONS WITH YOU, WE WILL MAKE A COPY OF THEM FOR OUR RECORDS.**

NAME AND DOSE	NAME AND DOSE	NAME AND DOSE
1. _____	2. _____	3. _____
4. _____	5. _____	6. _____
7. _____	8. _____	9. _____

**IV-ALLERGIES**

PCN  SULFA  CODIENE  SHELLFISH  LATEX  OTHER \_\_\_\_\_

**V-PAST MEDICAL HISTORY**

PREVIOUS SURGERY: \_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_ DATE: \_\_\_\_\_

HOSPITALIZATIONS: \_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_ DATE: \_\_\_\_\_

**VI-MEDICAL CONDITIONS**

- AIDS/HIV
- ALCOHOLISM
- ANGINA
- ATRIAL FIBRILLATION
- ARTHRITIS
- BLADDER INFECTION
- BLEEDING DISORDER
- BRONCHITIS
- CANCER
- CHEMICAL DEPENDENCY

- DEPRESSION
- DIABETES
- ELEVATED CHOLESTEROL
- EMPHYSEMA
- GALL BLADDER DISEASE
- HEART ATTACK
- HEPATITIS
- HIGH BLOOD PRESSURE
- INTESTINAL PROBLEMS
- KIDNEY DISEASE

- MENTAL/NERVE DISORDER
- PANCREATITIS
- PHLEBITIS/BLOOD CLOTS
- PNEUMONIA
- SKIN DISEASE
- STROKE
- THYROID DISEASE
- TUBERCULOSIS
- ULCERS

OTHER: \_\_\_\_\_

**VII-SOCIAL HISTORY**

DO YOU SMOKE?  YES  NO PACKS/DAY \_\_\_\_\_ YEARS: \_\_\_\_\_

DO YOU DRINK ALCOHOL?  YES  NO AVERAGE WEEKLY CONSUMPTION: \_\_\_\_\_

FEMALE PATIENTS: ORAL CONTRACEPTION?  YES  NO ANY CHANCE YOU ARE PREGNANT?  YES  NO

**VIII-FAMILY HISTORY**

(CHECK ALL THAT APPLY)  NO DISEASES

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> CANCER              | <input type="checkbox"/> ASTHMA         | <input type="checkbox"/> STROKE                  |
| <input type="checkbox"/> DIABETES            | <input type="checkbox"/> TUBERCULOSIS   | <input type="checkbox"/> SEIZURES                |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> EXCESSIVE BLEEDING      |
| <input type="checkbox"/> HEART DISEASE       | <input type="checkbox"/> ARTHRITIS      | <input type="checkbox"/> PROBLEM WITH ANESTHESIA |
- OTHER: \_\_\_\_\_

**IX-REVIEW OF SYSTEMS**

(CHECK ALL THAT APPLY)

**GENERAL**

- NONE
- FEVER
- CHILLS
- WEIGHT CHANGE

**HEAD**

- NONE
- HEADACHES
- DIZZINESS
- HEARING LOSS
- RINGING IN EARS
- DOUBLE/BLURRED VISION
- SORE THROAT/HOARSENESS
- RECENT COLD

**Chest**

- NONE
- SHORTNESS OF BREATH
- CHEST PAIN
- PALPITATIONS
- WHEEZING
- RHEUMATIC FEVER
- HEART MURMUR

**ABDOMEN**

- NONE
- NAUSEA/VOMITING
- DIFFICULTY SWALLOWING
- GAS/BLOATING
- INDIGESTION
- ABDOMINAL PAIN
- DIARRHEA
- BLOODY STOOLS
- HEMORRHOIDS

**URINARY**

- NONE
- BLOOD IN URINE
- BURNING SENSATION
- BLADDER/KIDNEY INFECTION
- FREQUENT URINATION
- INCONTINENCE

**ORTHOPAEDIC**

- NONE
- FRACTURE/DISLOCATION

- JOINT STIFFNESS
- JOINT PAIN
- RHEUMATOID DISEASE
- GOUT
- SWELLING OF FEET

**SKIN**

- NONE
- RASH/ITCHING
- PSORIASIS
- REYNAUD'S
- VARICOSE VEINS

**EMOTIONAL**

- NONE
- DEPRESSION
- BIPOLAR DISORDER
- SEIZURE DISORDER

**OTHER:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_