

Patient Health History

Name: (LAST) _____ (FIRST) _____ (MIDDLE) _____

Today's Date: _____

Date of Birth: _____ Age: _____ Gender: Male Female

Right-handed Left-handed

Were you referred to our office by friend, relative, current treating physician or other? Yes No

Were you treated as an emergency by one of our doctors prior to this visit? Yes No

Doctors name: _____

Primary Care Physician (PCP) Name: _____

CHIEF COMPLAINT: (REASON FOR VISIT) _____

Date of injury: _____ Where did injury occur: _____

Is this job related? Yes No If yes, describe how it occurred: _____

Prior industrial injuries? Yes No If yes, describe how it occurred: _____

Prior injury area of complaint? Yes No If yes, describe injury: _____

Job Title: _____ Length of employment in this capacity: _____

HISTORY OF PRESENT ILLNESS / INJURY:

(PLEASE CHECK ANY OF THE FOLLOWING THAT BEST DESCRIBE YOUR PROBLEM)

Area(s) of Pain:

Right Left Hand Wrist Elbow Shoulder
 Bilateral Hip Knee Back Neck Other: _____

Severity of Pain:

0-1 No pain 2-3 Mild pain 4-5 Discomforting 6-7 Distressing 8-9 Intense 10 Unbearable

Quality of Pain:

Sharp Dull Throbbing Burning Aching

Duration of Pain:

Intermittent Constant Minutes

Timing of Pain (makes pain worse):

With Exercise Activity Nightly At rest Sitting Walking

Modifying factors (makes pain better):

Rest Heat Cold Elevation Standing Sitting Walking

Context of Pain:

- Worsening Recurrent Improving

Associated signs:

- Bruising Numbness Tingling Buckling Locking Weakness Dislocating

PRIOR TREATMENTS FOR THIS CONDITION: (PLEASE CHECK ALL THAT APPLY)

- None
- Nonsteroidal anti-inflammatory drugs (Ibuprofen, Aleve, Celebrex, etc)
- Narcotic pain medications (Vicodin, Norco, Percocet, Tramadol, Oxycontin, Fentanyl patch, etc.)
- Other medications (Neurontin, Cymbalta, Amitriptyline, Steroids, Muscle Relaxants, etc): which ones? _____
- Physical Therapy (hand, wrist, shoulder, knee, etc): which ones? _____
- Injections (hand, wrist, shoulder, knee, etc): which ones? _____
- Chiropractic: name of doctor: _____
- Pain management specialist: name of doctor _____
- Other Treatments (acupuncture, homeopathic, herbal, other): _____
- Surgery (include specific details in past surgical history, page 3)
- Fractures: _____
- Have you ever had local/general anesthesia: Yes No
Any problems with anesthesia: Yes No If yes, describe problem: _____

Spine Patients ONLY:

- Spinal injections (epidural, facet joint, other): type of injection _____
Did pain get better after injection? Yes No _____
How long did pain relief from injection last? _____
- Spinal Surgery: List type of surgery, when it was done and name of surgeon: _____

PAST MEDICAL HISTORY:

Last physical exam: _____
Other specialty physicians: _____

ILLNESSES: Please place a checkmark if you have or have had any of the following illnesses:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Depression | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epstein Barr | <input type="checkbox"/> Keloids | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Gout | <input type="checkbox"/> Lupus | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraine | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Spinal Stenosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Myelopathy | <input type="checkbox"/> Spondylolisthesis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Myocardial Infarction | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Nervous Condition | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Tuberculosis |

- Cancer
- Cerebral Palsy
- Currently Pregnant
- Degenerative Disc
- High Blood Pressure
- High Cholesterol
- HIV
- Osteoporosis
- Parkinson's
- Peptic Ulcer
- Valley Fever
- Other Illnesses _____
- No illnesses

PRIOR SURGERIES: Please place a check mark if you have had procedures on any body part listed. Please include the specific procedure, right/left or bilateral and approximate date, in the space provided.

- Abdominal
- Amputation
- Ankle
- Appendectomy
- Arm
- Back Surgery
- Biopsy
- Bladder
- Bowel
- Breast
- Cardiac (Heart)
- Carotid
- Carpal Tunnel
- Cataracts
- Dental
- Dermatology
- Discectomy
- Elbow
- Feet
- Finger
- Fracture
- Gallbladder
- Hand
- Head/eyes/ears/nose/throat
- Heart Stent
- Hernia
- Hip
- Hip Replacement
- Kidney
- Knee
- Knee Arthroscopy
- Knee Replacement
- Laminectomy
- Liver
- Lungs
- OB/Gyn (Female)
- Pacemaker
- Parathyroidectomy
- Plastic Surgery
- Prostatectomy
- Rectal
- Shoulder
- Shoulder Replacement
- Spinal Fusion
- Spleen Removed
- Stomach
- Testicle
- Thyroid
- Tonsillectomy
- Trachea
- Ulcers
- Vasectomy
- Vertebral
- Disc Replacement
- Wrist
- Other Surgeries _____
- No past surgical history

MEDICATIONS: Prescription, over-the-counter, vitamins and herbals.

Name	Strength

ALLERGIC/IMMUNOLOGIC: List food/environmental allergies.

- No known allergies
- Latex sensitivity/allergy

Substance	Effect

FAMILY HISTORY: Please place a check mark if there is a family history of the following:

Family Member: Father – F, Mother – M, Sister – S, Brother – B, Extended Family - E

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Alcoholism ____ | <input type="checkbox"/> Cancer-Breast ____ | <input type="checkbox"/> Diabetes ____ | <input type="checkbox"/> High Cholesterol ____ |
| <input type="checkbox"/> Alzheimer's ____ | <input type="checkbox"/> Cancer-Colon ____ | <input type="checkbox"/> Gout ____ | <input type="checkbox"/> Kidney Problems ____ |
| <input type="checkbox"/> Arthritis ____ | <input type="checkbox"/> Cancer-Other ____ | <input type="checkbox"/> Heart Disease ____ | <input type="checkbox"/> Malignant Hyperthermia _ |
| <input type="checkbox"/> Bleeding Disorder ____ | <input type="checkbox"/> Cancer-Prostate ____ | <input type="checkbox"/> High Blood Pressure ____ | <input type="checkbox"/> Spine Problems ____ |
| <input type="checkbox"/> Other family history of ____ | | | <input type="checkbox"/> No family history |

SOCIAL HISTORY:

Work in the home Student Education (years and degrees): _____

Single Married Divorced Separated Widowed

Do you live alone? Yes No

Do you exercise? Daily Weekly Monthly Rarely Never

Hobbies: _____

What types of exercise and /or sports: _____

Are you on a special diet? Yes No Describe: _____

Drink alcohol? Yes No Formerly If "yes" or "formerly", how often? _____

Do you smoke? Yes No Formerly If "yes" or "formerly", how often? _____

Do you use illegal drugs? Yes No If "yes", which one(s) _____

Are you adopted? Yes No

Women: Are you pregnant? Yes No Last menstrual cycle: _____

REVIEW OF SYSTEMS: Please indicate if you have any of the following conditions or symptoms

Cardiovascular

- Chest pain
- Elevated Blood Pressure
- Irregular Heartbeat/Palpitations
- Leg Edema
- Syncope

Constitutional

- Chills
- Decreased Appetite
- Fatigue
- Fever
- Night Sweats
- Weight loss

Metabolic/Endocrine

- Adrenal Insufficiency
- Diabetes (Insulin Dependent)
- Diabetes (Non-insulin Dependent)
- Osteoporosis
- Thyroid Disorder

GI – Gastrointestinal

- Black Tarry Stools
- Bowel Incontinence
- Constipation
- Diarrhea
- Jaundice
- Nausea
- Rectal Bleeding
- Vomiting

GU – Genitourinary

- Difficulty Urinating
- Frequently Urinating
- Kidney Stones
- Sexual Dysfunction
- Urinary Incontinence

Head/Eyes/Ears/Nose/Throat

- Blurry Vision
- Difficulty swallowing
- Double vision
- Hearing Loss
- Hoarse Voice
- Nose Bleeds
- Ringing in ears
- Wears glasses/contacts

Hematologic/Lymphatic

- Anemia
- Bleeding
- Bruising
- Node swelling
- Slow to heal after cuts

Neurologic

- Dizziness
- Headaches
- Numbness
- Seizures
- Stroke
- Tingling

Skin

- Chronic wounds
- Rash
- Skin Lesions
- Ulcerations

Psychiatric

- Anxiety
- Confusion
- Depression
- Insomnia
- Memory Loss
- Suicidal Ideation

Musculoskeletal

- Back pain
- Difficulty walking
- Fibromyalgia
- Joint pain
- Muscle Cramping
- Muscle weakness
- Neck pain

Respiratory

- Cough
- Hemoptysis
- Orthopnea
- Shortness of Breath
- Wheezing