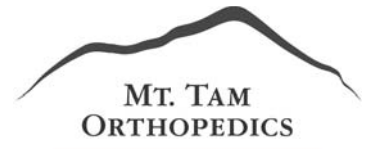


Medical History Form



Patient Name: _____ Appointment Date: _____ with Dr. _____

Age: _____ Sex: F M Height: _____ Weight: _____ Dominant hand: R L

This form is used to gather information so that my doctor can maximize the time used to examine me and answer my questions about my condition and treatment options. I certify that the following information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may make in the completion of this form.

Patient Signature (Date) Physician Signature (Date)

Have you ever been treated by this Physician? Y N

What body part are you **scheduled** for today? _____

How long has this body part been a problem? Days _____ Weeks _____ Months _____ Years _____

In this section, check the **ONE BOX** which best describes how your problem started. Then answer the question below the box you checked. Use as much space to the right as needed.

NO INJURY (or onset was: Gradual or Sudden)
Please indicate why you think it started?

INJURY (Accident Sport (NOT Auto or Work)
Date: _____ Please specify where and how it happened.
What Sport? _____ School? _____

INJURY AT WORK Date: _____
From a: Lift Twist Fall Bend Pull Reach

WORK RELATED (BUT NO INJURY)
Date: _____ How did your job cause the problem?

AUTO ACCIDENT Date: _____ How was your car hit?

Comments:

On a scale of 0 – 10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? Sharp Dull Stabbing Throbbing Aching Burning

The pain is: Constant Comes and goes (intermittent)

Does your pain wake you from your sleep? Y N

Do you have: Swelling Bruises Numbness Tingling Weakness Locking/Catching
 Buckling/Giving Way

Since my problem started, it is: Getting Better Getting Worse Unchanged

What makes your symptoms worse? Standing Walking Lifting Exercise Twisting Lying in bed
 Bending Squatting Kneeling Stairs Coughing Sneezing

Which makes your symptoms better: Rest Elevation Ice Heat Other: _____

Have you had any of these treatments? Injection: Y N Brace: Y N Physical Therapy: Y N Cane/Crutch: Y N

What tests/scans have you had for this problem:
 X-Rays MRI CAT Scan Bone Scan Nerve Test (EMG/NCV) Where? _____

Please list any surgical procedures you have had on this body part?
Procedure #1 _____ Surgeon _____ City _____ Date _____
Procedure #2 _____ Surgeon _____ City _____ Date _____

Please complete reverse side of this form

General Medical and Social History

Have you ever had problems with general anesthesia? Yes No

Present **Medications** taken regularly: _____

Allergies to Medications: _____

Prior and current illnesses and injuries: _____

List all surgeries and hospitalizations: _____

Alcohol: Don't Drink: _____ Quantity Socially: _____ Quantity Daily: _____

Tobacco: Don't Smoke: _____ Smoker: _____ # of Years: _____ # of Packs: _____

Are you currently having or have you ever had a problem with the following:

	Yes	No	Describe all "Yes" responses
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung/Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcer or Stomach Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
GI Bleed	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia or other Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis/Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Medical Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family History

Does your immediate family have a history of any of the following medical conditions?

	Yes	No	Relationship
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____