

# PATIENT HISTORY

NAME: \_\_\_\_\_

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

Occupation: \_\_\_\_\_ Age: \_\_\_\_\_

Sex: \_\_\_\_\_

Student:  No  Yes School: \_\_\_\_\_ Sports: \_\_\_\_\_

**HISTORY OF INJURY: Auto Accident yes or no \* Work accident yes or no \* Other accident yes or no**

Date of Onset: \_\_\_\_\_ LEFT OR RIGHT \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

**Have you sought medical attention for this problem?**  NO  YES

If YES, from whom: \_\_\_\_\_ What treatment was given? \_\_\_\_\_

Were x-rays, MRIs, or other studies performed? If so, what? \_\_\_\_\_ Did you bring them today?  No  Yes

## **PAST HISTORY:**

### **LIST CURRENT MEDICATIONS/HERBALS/DIET/OVER THE COUNTER**

<b><u>MEDICATION</u></b>	<b><u>DOSAGE</u></b>	<b><u>REASON</u></b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**If you need more space, please turn to back side of this sheet**

ARE YOU TAKING A BLOOD THINNER:  NO  YES  Coumadin  Plavix  Lovenox  Aspirin

LIST **ALLERGIES** TO MEDICATIONS or check  None: \_\_\_\_\_

Illnesses:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> None              | <input type="checkbox"/> Depression          | <input type="checkbox"/> HIV                   | <input type="checkbox"/> Rheumatoid       |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Diabetes I          | <input type="checkbox"/> High cholesterol      | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Diabetes II         | <input type="checkbox"/> Irregular heart beat  | <input type="checkbox"/> Sleep apnea      |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Dialysis            | <input type="checkbox"/> Kidney stones         | <input type="checkbox"/> Staph infections |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney disease        | <input type="checkbox"/> Strokes          |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> GI Bleed            | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Thyroid disease  |
| <input type="checkbox"/> Blood Clots       | <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Poor circulation      | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Chemotherapy      | <input type="checkbox"/> Hepatitis A         | <input type="checkbox"/> Pulmonary embolism    |   |
|  | <input type="checkbox"/> Hepatitis B         | <input type="checkbox"/> Reflux                |   |
|  | <input type="checkbox"/> Hepatitis C         |  |   |

**Other – Please explain:** \_\_\_\_\_

**Operations:** Please **check** and **date** all that apply to you.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> None                   | <input type="checkbox"/> Hand/fingers _____ | <input type="checkbox"/> Foot/toes _____  |
| <input type="checkbox"/> Appendectomy _____     | <input type="checkbox"/> Wrist _____        | <input type="checkbox"/> Neck _____       |
| <input type="checkbox"/> Colon Surgery _____    | <input type="checkbox"/> Arm _____          | <input type="checkbox"/> Spine/back _____ |
| <input type="checkbox"/> Gallbladder _____      | <input type="checkbox"/> Elbow _____        | _____                                     |
| <input type="checkbox"/> Hernia Repair _____    | <input type="checkbox"/> Shoulder _____     | _____                                     |
| <input type="checkbox"/> Hysterectomy _____     | <input type="checkbox"/> Hip _____          | _____                                     |
| <input type="checkbox"/> Cardiac Bypass _____   | <input type="checkbox"/> Knee _____         | _____                                     |
| <input type="checkbox"/> Cardiac Stents _____   | <input type="checkbox"/> Ankle _____        | _____                                     |
| <input type="checkbox"/> Pain Management _____  | <input type="checkbox"/> Leg _____          | _____                                     |
| <input type="checkbox"/> Other – Please explain |   |   |

Have you had a general anesthetic:  YES  NO Any Problems? \_\_\_\_\_

Transfusions:  No  Yes: \_\_\_\_\_

Hospitalizations Other Than Surgery  No  Yes: \_\_\_\_\_

**FAMILY HISTORY:**

Age

Living/Deceased

Arthritis/ Illnesses/Cause of Death

**Mother:** \_\_\_\_\_

**Father:** \_\_\_\_\_

**Brothers:** \_\_\_\_\_

**Sisters:** \_\_\_\_\_

**Children:** \_\_\_\_\_

**SOCIAL HISTORY:** Marital Status:  Single  Married  Divorced  Widowed

**Occupation:** \_\_\_\_\_

Physical  Sedentary  Retired  Homemaker  Student (where?) \_\_\_\_\_

Please explain physical requirements: \_\_\_\_\_

Regular Duty  Light Duty Explain: \_\_\_\_\_

Off Work Since: \_\_\_\_\_ Reason: \_\_\_\_\_

Home:  House  Apartment  Town home  Trailer  Assisted Living

Do you live alone:  Yes  No With whom do you live? \_\_\_\_\_

Do you have stairs in your home?  No  Yes, explain: \_\_\_\_\_

Have you fallen in your home?  No  Yes, explain: \_\_\_\_\_

Have you fallen outside your home in the last year?  No  Yes, explain: \_\_\_\_\_

Are you the caretaker for an elderly family member? \_\_\_\_\_

Have you had a bone density test in the last year?  No  Yes

**RISK FACTORS:**

**Tobacco:**  No  Yes  Cigarettes  Cigars  Chewing Tobacco  Pipe  Nicotine Patches

Packs/Cigars/Pipes per day: \_\_\_\_\_ Number of Years: \_\_\_\_\_

Stopped Tobacco Use: \_\_\_\_\_ Number of years used: \_\_\_\_\_

**Alcohol:**  No  Occasionally  Daily Drinks per day: \_\_\_\_\_

History of Alcoholism, explain: \_\_\_\_\_

**Substance/ Drug Abuse:**  No  Yes, explain: \_\_\_\_\_

Pain Medication Abuse: \_\_\_\_\_

**Exercise:**  Daily  Weekly  Monthly  Rarely  Never

Type of Exercise: \_\_\_\_\_

Sports Played: \_\_\_\_\_

**REVIEW OF SYSTEMS:** (Please check all that apply)

**General**

- Weight loss
- Weight gain
- Chills
- Fevers
- Night sweats

**Skin**

- Rash
- Lesions

**Infections**

- Staph
- Other

**HEENT**

- Hay fever
- Postnasal discharge
- Hoarseness
- Visual Problems
- Hearing Problems

**Cardiovascular**

- Chest pain (angina)
- Palpitations (rapid heartbeat)
- Irregular heartbeat (arrhythmia)
- Rheumatic fever
- Swollen ankles (pedal edema)

**Pulmonary**

- Shortness of breath
- Wheezing
- Coughing
- Coughing up blood (hemoptysis)

**Genitourinary**

- Frequent urination (frequency)
- Urgent urination (urgency)
- Painful urination (dysuria)
- Need to awaken to urinate (nocturia)
- Blood in urine (hematuria)
- Penile or vaginal discharge
- Kidney stone pain (renal colic)

**Gastrointestinal**

- Indigestion
- Nausea
- Vomiting
- Vomiting blood (hematemesis)
- Yellow skin
- Abdominal pain
- Constipation
- Diarrhea
- Black stools (melena)
- Rectal bleeding

**Psychiatric**

- Anxiety
- Depression
- Other \_\_\_\_\_

**Lymphatics**

- Lymph node swelling
- Node tenderness

**Endocrine**

- Excessive urination (polyuria)
- Excessive thirst (polydipsia)
- Excessive appetite polyphagia)
- Heat intolerance
- Cold intolerance

**Neurological**

- Loss of consciousness
- Headaches
- Dizziness
- Seizures (fits)
- Fainting spells

**FEMALES:**

**Are you pregnant?**

No  Yes

Date of last menstrual cycle

\_\_\_\_\_

**HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ **DOMINANCE:** Right Hand \_\_\_\_\_ (or) Left Hand \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I certify that the information provided above is correct and true.