PATIENT HISTORY FORM

Today's Date: _____

Name:_____ **Weight_____ Height_____ Age_____**

Date of Birth:_____

Work Related: YES NO Auto Related: YES NO

Referring Physician:_____ Date Of Injury: _____

CHIEF COMPLAINT

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? (DESRIBE YOUR PROBLEM IN DETAIL)

_____

_____

_____

Have You Had an X-Ray, CT Scan, MRI, EMG or Bloodwork? (Circle Any) Where?_____

HISTORY OF PRESENT ILLNESS

Location of the Problem
WRIST HAND ELBOW SHOULDER

On A Scale Of 1-10, With 10 Being The Most Severe,
Circle The Number That Best Describes The Problem.
1 2 3 4 5 6 7 8 9 10

When Did You First Notice The Problem?
Days Ago ____Weeks Ago ____ Months Ago
Other: _____

Pain in area is (please circle): Daily or Occasionally

Does It Interfere With Your Normal Daily Routine?
Y N If Yes Please Explain _____

PAST MEDICAL, FAMILY AND SOCIAL HISTORY

ALLERGIES: ( ) NONE

Drug (Including Anesthetics)/Food/Other

_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

Y N

☐☐ Do you smoke? If Yes, # packs/day:
☐☐ Do you drink? If Yes, # drinks/day:
☐☐ Do you use street drugs?
☐☐ Are you on any special diets?
☐☐ Are you on any special food restrictions?
Specify: _____

PLEASE LIST ALL CHRONIC OR SERIOUS ILLNESSES

( ) NONE _____

_____
_____
_____

PLEAE LIST ALL MEDICATIONS YOU ARE CURRENTLY ON

( ) NONE _____

_____
_____
_____

PAST SURGERIES/HOSPITALIZATION, OR ACCIDENTS **( ) NONE** (REASON & DATE)

_____

_____

_____

Family History	Current Age	Age of Death	Serious Illnesses (Examples: Diabetes, Cancer, Heart, Kidney, Alcohol, High Blood Pressure, Etc)
Father			
Mother			
Brothers			
Sisters			

REVIEW OF SYMPTOMS

DO YOU NOW OR HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING?

CIRCLE YES OR NO AND PLEASE EXPLAIN ANY YES ANWSERS IN THE SPACES PROVIDED

CONSTITUTIONAL SYMPTOMS

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other_____

EYES

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other_____

ALLERGIC/IMMUNOLOGIC

Hay Fever	Y	N
Drug allergies	Y	N

Other_____

NEUROLOGICAL

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	y	N

Other_____

ENDOCRINE

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other_____

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	y	N
Indigestion/heartburn	Y	N

Other_____

CARDIOVASCULAR

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Other_____

INTEGUMENTARY

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other_____

MUSCULOSKELETAL

Joint pain	Y	N
Neck pain	Y	N
Back pain	y	N

Other_____

EAR/NOSE/THROAT/MOUTH

Ear infection	Y	N
Sore throat	Y	N
Sinus problem	Y	N

Other_____

GENITOURINARY

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N

Other_____

RESPIRATORY

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other_____

HEMATOLOGIC/LYMPHATIC

Swollen glands	Y	N
Blood clotting problem	y	N

Other_____

PSYCHOLOGIC

Are you generally satisfied with your life? Y N

Do you feel severely depressed? Y N

Have you considered suicide? Y N

Other_____

PHYSICIAN SIGNATURE:_____ DATE:_____