PATIENT HISTORY FORM

DATE _____

NAME _____ AGE _____ SEX: Male_____ Female _____

WHO REFERRED YOU TO OUR OFFICE? _____

REASON FOR TODAY'S VISIT: _____

HAVE YOU EVER BEEN TREATED FOR THIS PROBLEM BEFORE?_____ IF YES, PLEASE GIVE DETAILS:_____

_____

DO YOU CONSIDER THIS A WORK RELATED INJURY? YES _____ NO_____

HISTORY OF PRESENT ILLNESS

PLEASE DESCRIBE YOUR INJURY: _____

DESCRIBE HOW YOUR INJURY HAPPENED:

_____

_____

DATE OF YOUR INJURY: _____

MEDICAL HISTORY

MEDICAL PROBLEMS YOU HAVE: _____

_____

_____

YOUR CURRENT MEDICATIONS AND DOSES: _____

_____

_____

YOUR PAST SURGERIES AND DATES: _____

_____

_____

LIST ALL ALLERGIES TO MEDICINES _____

_____

NAME OF YOUR PRIMARY CARE DOCTOR: _____ CARDIOLOGIST _____

SOCIAL HISTORY

YOUR OCCUPATION:_____ MARITAL STATUS:_____ HOW MANY CHILDREN:_____

YOUR PERSONAL HABITS: **DO YOU?**	**NO**	**YES**	**IF YES, HOW MUCH**
SMOKE	_____	_____	_____
DRINK ALCOHOL	_____	_____	_____

HAVE YOU EVER USED INTRAVENOUS STREET DRUGS? NO_____ YES_____

REVIEW OF SYSTEMS

DO YOU HAVE ANY OF THE FOLLOWING:

	NO	YES		NO	YES
HEADACHES	______	______	ASTHMA OR EMPHYSEMA	______	______
DIZZINESS	______	______	CANCER NO_____YES_____LOCATION______________		
BLURRED VISION	______	______	DIABETES	______	______
BLACKOUT SPELLS	______	______	EPILEPSY	______	______
SHORTNESS OF BREATH	______	______	GASTRITIS	______	______
PRODUCTIVE COUGH	______	______	HEART DISEASE	______	______
CHEST PAIN	______	______	HEPATITIS	______	______
RECURRENT NAUSEA/VOMITING	______	______	HIGH BLOOD PRESSURE	______	______
ABDOMINAL PAIN	______	______	HIV	______	______
ABNORMAL COLOR OF STOOL OR URINE	______	______	LUNG DISEASE	______	______
			STROKE	______	______
BURNING ON URINATION	______	______	THYROID DISEASE	______	______
NUMBNESS IN ARMS OR LEGS	______	______	ULCERS	______	______

(WOMEN ONLY): COULD YOU BE PREGNANT? _______ Yes _____ No Height______ Weight______

FAMILY HISTORY

PLEASE LIST ANY HEREDITARY ILLNESSES THAT RUN IN YOUR FAMILY:

____

Date	No Change	Patient Signature		Date	No Change	Patient Signature