Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Patient History

Please answer every question.

STAFF: Responses in boxes and handwritten items must be entered **MANUALLY**.

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

Please use a # 2 pencil.
Fill in the complete oval as shown...

PAST HISTORY

Please indicate if YOU have a history of, or currently have any of the following:
(Mark all that apply. If none, mark "NONE of the Above.")

PAST	ACTIVE		PAST	ACTIVE	
○	○	Abnormal Rhythm	○	○	High Blood Pressure
	○	AIDS / HIV	○	○	Irritable Bowel Syndrome
○	○	Arthritis - Osteoarthritis	○	○	Keloid Scar
○	○	Arthritis - Rheumatoid	○	○	Malignant Hyperthermia
○	○	Arthritis - Other	○	○	MRSA
○	○	Asthma	○	○	Multiple Sclerosis
○	○	Bleeding Disorders	○	○	Neuropathy
○	○	Blood Clots	○	○	Osteoporosis
○	○	Bone Infection	○	○	Oxygen Dependence
○	○	Bronchitis	○	○	Pacemaker
○	○	Cancer	○	○	Polio
○	○	Crohn's Disease	○	○	Psoriasis
○	○	Delayed Wound Healing	○	○	Psychiatric Disorder
○	○	Depression	○	○	Recreational Drug Use
○	○	Diabetes	○	○	Reflux / GERD
○	○	Difficulty with Anesthesia	○	○	RSD
○	○	Emphysema	○	○	Seizures
○	○	Fibromyalgia	○	○	Sprains / Ligament Injury
○	○	Gallbladder Disease	○	○	Stomach Ulcers
○	○	Gout	○	○	Stroke
○	○	Heart Attack	○	○	Substance Abuse
○	○	Hepatitis	○	○	Thyroid Disease
○	○	Hiatal Hernia			

○ **NONE of the Above**

Other Significant Disease *(please specify)*: _____

To your knowledge, do you have a history of sleep apnea? yes ○ no ○

If yes, do you use a C-Pap machine? yes ○ no ○

SURGICAL HISTORY

Please indicate if YOU have had any of the following surgeries:
(Mark all that apply. If none, mark, "I have had NO SURGERIES.")

○ **I have had NO SURGERIES** *(No need to complete the SURGICAL HISTORY section.)*

Fracture Surgery **If yes, which body part?** *(please specify)* _____

○ Aneurysm Repair	○ Heart Stent	○ Pacemaker
○ Appendectomy	○ Heart Valve Replacement	○ Thyroidectomy
○ Bladder Surgery	○ Implanted Defibrillator	○ Tonsillectomy
○ Carotid Artery Surgery	○ Kidney Stone Removal	○ Ulcer Surgery
○ Gallbladder Surgery	○ Leg Circulation Surgery	
○ Heart Bypass Surgery	○ Lung Surgery	

Spinal Decompression	○ Neck	○ Low Back
Spinal Fusion	○ Neck	○ Low Back
Disc Surgery	○ Neck	○ Low Back

SURGICAL HISTORY continued on next page.

SURGICAL HISTORY continued from previous page.

Carpal Tunnel Surgery	◯ Left	◯ Right	◯ Both
Rotator Cuff Surgery	◯ Left	◯ Right	◯ Both
Arthroscopic Shoulder Surgery	◯ Left	◯ Right	◯ Both
Total Shoulder Surgery	◯ Left	◯ Right	◯ Both
Hip Fracture Surgery	◯ Left	◯ Right	◯ Both
Total Hip Surgery	◯ Left	◯ Right	◯ Both
Partial Hip Surgery	◯ Left	◯ Right	◯ Both
Arthroscopic Knee Surgery	◯ Left	◯ Right	◯ Both
Total Knee Surgery	◯ Left	◯ Right	◯ Both
Partial Knee Surgery	◯ Left	◯ Right	◯ Both
Foot Surgery	◯ Left	◯ Right	◯ Both

Other Surgery *(please specify):* _____

ALLERGIES

Please list any medications you are sensitive to and the reaction:

◯ **I have NO KNOWN ALLERGIES**

Name of Medication	Reaction

Have you ever had a reaction to any of the following?
◯ eggs ◯ latex ◯ rubber ◯ adhesive tape ◯ iodine ◯ metal ◯ shellfish

FAMILY HISTORY

Please indicate if YOUR FAMILY has a history of the following:
(ONLY include parents, grandparents, siblings and children. Mark all that apply. If none, mark "NONE of the Above.")

- ◯ **Family History UNKNOWN**
- ◯ Arthritis
- ◯ Asthma
- ◯ Bleeding Disorder(s) *(e.g., Hemophilia, Clotting Problems, Von Willebrand's Disease, Sickle Cell)*
- ◯ Blood Clots
- ◯ Cancer
- ◯ Diabetes
- ◯ Difficulty with Anesthesia
- ◯ Disease(s) of Bones *(e.g., Osteoporosis)*
- ◯ Disease(s) of Muscles *(e.g., Fibromyalgia)*
- ◯ Disease(s) of Nervous System *(e.g., MS)*
- ◯ Heart Disease
- ◯ Infectious Disease(s)
- ◯ Mental Disorder(s) *(e.g., Depression)*
- ◯ Osteoarthritis
- ◯ Rheumatoid Arthritis
- ◯ **NONE of the Above**

Do you have a family history of any other diseases you would like the doctor to know about? If yes, please explain:

_____

_____

SOCIAL HISTORY

ALCOHOL USE	(number of times…)	never ◯	1 ◯	2 ◯	3 ◯
How often do you use alcohol?		4 ◯	5 ◯	6 ◯	7+ ◯
	(per…)		week ◯	month ◯	year ◯
How many drinks do you have per occasion?		1-2 ◯	3-5 ◯	6-9 ◯	10+ ◯
How often do you have more than five drinks per occasion?			never ◯ rarely ◯		occasionally ◯ frequently ◯

SOCIAL HISTORY continued on next page.

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Patient's Printed Name: _____

SOCIAL HISTORY continued from previous page.

TOBACCO USE

What is your tobacco use status? (e.g., cigarettes, chew, cigar)
current (every day) ○ previous ○
occasional ○ never ○

At what age did you begin using tobacco?

If you quit using tobacco, at what age did you quit?

How many times per day do you use tobacco?

10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

EXAMPLE
If you started smoking at the age of 21, you would fill in the ovals like this:
10 20 30
1 2 3

Are you exposed to passive (second hand) smoke? yes ○ no ○

EXERCISE

Do you exercise? yes ○ no ○

If yes, what type? bicycling ○ running ○ swimming ○ walking ○ aerobics ○ other ○

If yes, how often? 0 ○ 3-4 / week ○ 7+ / week ○ 1-2 / week ○ 5-6 / week ○

WORK AND OTHER SOCIAL HISTORY

Marital status: single ○ domestic partner ○ widowed ○ married ○ divorced ○

Do you have children? yes ○ no ○

Do you live: with family ○ nursing home ○ alone ○ assisted living ○ other ○

Are you currently working? full-time ○ part-time ○ no ○ student ○ retired ○

If no, when did you last work? _____

If currently working:
Occupation: _____ How long? _____

Company name: _____

Are you currently on any work restrictions? yes ○ no ○

If yes, what are they? _____

Primary Care Physician: _____

ANY OTHER ITEMS THE PHYSICIAN SHOULD KNOW:

Date	Remarks