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# Patient History

Please answer every question

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

PLEASE PRINT PATIENT'S LAST NAME

## Marking Instructions

**Please fill in the oval completely**

**CORRECT:** ● **INCORRECT:** ⊗ ○

PLEASE PRINT PATIENT'S FIRST NAME | MIDDLE INITIAL | PATIENT'S DATE OF BIRTH (Month, Day, Year)

**Visit Date:**

**Primary Care Physician:**

**Clinic Name:**

○ No Primary Care Physician

**Referring Physician:**

**Clinic Name:**

○ No Referring Physician

**Work Comp QRC:**

**Skilled Nursing Facility:**

## 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 ○

## PAST HISTORY

**Please indicate if YOU have a history of, or currently have any of the following:**
(Mark all that apply. If none, mark "**NO SIGNIFICANT MEDICAL HISTORY**.")

○ **NO SIGNIFICANT MEDICAL HISTORY**

| PAST | ACTIVE | |
|---|---|---|
| ○ | ○ | Abnormal Rhythm |
| | ○ | AIDS / HIV |
| ○ | ○ | Arthritis - Osteoarthritis |
| ○ | ○ | Arthritis - Rheumatoid |
| ○ | ○ | Arthritis - Other |
| ○ | ○ | Asthma |
| ○ | ○ | Bleeding Disorders |
| ○ | ○ | Blood Clots |
| ○ | ○ | Bone Infection |
| ○ | ○ | Bronchitis |
| ○ | ○ | Cancer |
| ○ | ○ | COPD |
| ○ | ○ | Crohn's Disease |
| | ○ | Currently Pregnant |
| ○ | ○ | Delayed Wound Healing |
| ○ | ○ | Depression |
| ○ | ○ | Diabetes |
| ○ | ○ | Difficulty with Anesthesia |
| ○ | ○ | Emphysema |
| ○ | ○ | Fibromyalgia |
| ○ | ○ | Gallbladder Disease |
| ○ | ○ | Gout |
| ○ | ○ | Heart Attack |

| PAST | ACTIVE | |
|---|---|---|
| ○ | ○ | Hepatitis |
| ○ | ○ | Hiatal Hernia |
| ○ | ○ | High Blood Pressure |
| ○ | ○ | Hypercholesterolemia |
| ○ | ○ | Irritable Bowel Syndrome |
| ○ | ○ | Keloid Scar |
| ○ | ○ | Malignant Hyperthermia |
| ○ | ○ | MRSA |
| ○ | ○ | Multiple Sclerosis |
| ○ | ○ | Neuropathy |
| ○ | ○ | Osteoporosis |
| ○ | ○ | Oxygen Dependence |
| ○ | ○ | Pacemaker |
| ○ | ○ | Polio |
| ○ | ○ | Psoriasis |
| ○ | ○ | Psychiatric Disorder |
| ○ | ○ | Recreational Drug Use |
| ○ | ○ | Reflux / GERD |
| ○ | ○ | RSD |
| ○ | ○ | Seizures |
| ○ | ○ | Sprains / Ligament Injury |
| ○ | ○ | Stomach Ulcers |
| ○ | ○ | Stroke |
| ○ | ○ | Substance Abuse |
| ○ | ○ | Thyroid Disease |

**Other Significant Disease** (please specify):

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

**If yes, do you use a CPAP machine?** yes ○ no ○

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# Patient History

Please answer every question

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

**Patient's Printed Name:** ____________________

## SURGICAL HISTORY

**Please indicate if YOU have had any of the following surgeries. Mark all that apply.**

◯ I Have Had NO SURGERIES

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

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

| Left | Right | Both | |
|---|---|---|---|
| ◯ | ◯ | ◯ | Partial Knee Surgery |
| ◯ | ◯ | ◯ | Total Knee Surgery |
| ◯ | ◯ | ◯ | Arthroscopic Knee Surgery |

| Neck | Low Back | |
|---|---|---|
| ◯ | ◯ | Spinal Decompression |
| ◯ | ◯ | Spinal Fusion |
| ◯ | ◯ | Disc Surgery |

**Fracture Surgery** (please specify body part): ____________________

**Other Surgery** (please specify): ____________________

## FAMILY MEDICAL HISTORY

◯ **Family History UNKNOWN** ◯ **NO SIGNIFICANT FAMILY MEDICAL HISTORY**

**Please indicate which family member(s) have had these illnesses:**

| | Father | Mother | Grandfather (Father's Side) | Grandmother (Father's Side) | Grandfather (Mother's Side) | Grandmother (Mother's Side) | Brother | Sister | Son | Daughter |
|---|---|---|---|---|---|---|---|---|---|---|
| Arthritis | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Asthma | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Bleeding Disorder (e.g., Hemophilia, Clotting Problems) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Blood Clots | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Cancer | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Diabetes | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Difficulty with Anesthesia | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Disease of Bones (e.g., Osteoporosis) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Disease of Muscles (e.g., Fibromyalgia) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Disease of Nervous System (e.g., MS) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Heart Disease | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Infectious Disease | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Mental Disorder (e.g., Depression) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Osteoarthritis | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Rheumatoid Arthritis | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

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

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# Patient History

Please answer every question

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

**Patient's Printed Name:** ____________________

## SOCIAL HISTORY

### ALCOHOL USE

**Do you drink alcoholic beverages?** yes ◯ no ◯ social drinker ◯ recovering alcoholic ◯

**If so, how much?**

**Number of drinks:** 1 ◯ 2-3 ◯ 4-5 ◯ 6+ ◯

**Per:** day ◯ week ◯ month ◯ year ◯

### TOBACCO USE

**What is your smoking status?** current (every day) ◯ occasional ◯ previous ◯ never ◯

**How many packs per day do you** (or did you) **smoke?** less than 1 ◯ 1-2 ◯ more than 2 ◯

**How many years have you** (or did you) **smoke?** less than 5 ◯ 5 ◯ 10 ◯ 15 ◯ 20 ◯ 25 ◯ 30 ◯ 35 ◯ 40+ ◯

**Do you use other tobacco products?** currently ◯ in the past ◯ never ◯

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

### EXERCISE

**Do you exercise?** yes ◯ no ◯

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

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

### DAIRY

**Do you consume dairy products?** yes ◯ no ◯

### WORK AND OTHER SOCIAL HISTORY

**Marital status:** single ◯ married ◯ domestic partner ◯ divorced ◯ widowed ◯

**Do you have children?** yes ◯ no ◯

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

**Height:** ____________________

**Weight:** ____________________

**Are you currently working?** no ◯ part-time ◯ full-time ◯ 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?** ____________________

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