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Direction of Feed

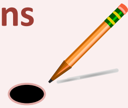
Patient Medical History

Please answer every question

STAFF: *Handwritten items must be entered* ***MANUALLY****.*

Marking Instructions

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



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH: Month / Day / Year

SURGICAL HISTORY

Please mark all surgeries that you have had. Include the year of each surgery.

	Year of Surgery		Year of Surgery
◯ Hysterectomy	____	◯ Colonoscopy	____
◯ Appendectomy	____	◯ Back Surgery	____
◯ Gallbladder	____	◯ Joint Surgery	____
◯ Cesarean Section	____	◯ Tonsillectomy / Adenoidectomy	____
◯ Hernia Repair	____	**Other:**	____
◯ Kidney	____		
◯ Heart Surgery	____	◯ **Never Had Surgery**	

PAST MEDICAL HISTORY

Please mark all conditions that you have had:

- ◯ Anemia
- ◯ Arthritis
- ◯ Asthma
- ◯ Bladder / Urinary Problems
- ◯ Bleeding / Blood Disorder
- ◯ Bowel Disease
- ◯ Cancer
- ◯ Chest Pain
- ◯ Congestive Heart Failure
- ◯ COPD
- ◯ Diabetes
- ◯ Heart Attack
- ◯ Heart Disease
- ◯ Hepatitis
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ HIV / AIDS
- ◯ Kidney Disease
- ◯ Leg Pain or Swelling
- ◯ Lung Disease
- ◯ Neurologic Disease
- ◯ Prostate Issues
- ◯ Rectal Bleeding
- ◯ Reflux
- ◯ Seasonal Allergies
- ◯ Shortness of Breath
- ◯ Stomach Disease
- ◯ Stroke
- ◯ Thyroid Issues
- ◯ Ulcers
- **Other:** ____
- ◯ **No Significant Medical History**

FAMILY MEDICAL HISTORY

Please mark all health problems that immediate family have had:

	MOTHER	FATHER	SISTER	BROTHER	DAUGHTER	SON
Diabetes	◯	◯	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯	◯	◯
Cancer	◯	◯	◯	◯	◯	◯
Arthritis	◯	◯	◯	◯	◯	◯
Bleeding Disorder	◯	◯	◯	◯	◯	◯
Osteoporosis	◯	◯	◯	◯	◯	◯
Stroke	◯	◯	◯	◯	◯	◯

Other
(please list condition and relative):
____
____
____

NONE ◯

TOBACCO USE

What is your smoking status? ◯ current (every day) ◯ current (some days) ◯ previous ◯ never

How many packs do you currently smoke per day? ◯ ½ ◯ 1 ◯ 1½ ◯ 2 ◯ 2½ ◯ 3 ◯ 3½ ◯ 4+

How many years have you been smoking? ◯ <1 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6-10 ◯ 11-20 ◯ 21-30 ◯ 31+

ALCOHOL USE

Do you consume alcohol? ◯ no ◯ rarely ◯ occasionally ◯ weekly

How many drinks do you currently consume per day? ◯ <1 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5+

How many years have you been drinking? ◯ <1 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6-10 ◯ 11-20 ◯ 21-30 ◯ 31+

OTHER

Do you take drugs recreationally? ◯ no ◯ in the past ◯ yes

Are you currently: ◯ working ◯ homemaker ◯ student ◯ retired ◯ unemployed

Are you: ◯ single ◯ married ◯ divorced ◯ widowed

With whom do you live? ◯ alone ◯ parents ◯ nursing / retirement home ◯ spouse ◯ children ◯ other

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SAMPLE

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Direction of Feed

Patient Medical History

Please answer every question

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

REASON FOR VISIT

- ◯ New Illness / Pain / Injury
- ◯ Follow Up Visit
- ◯ Sports Injury
- ◯ On the Job Injury
- ◯ Recurrent Illness / Injury
- ◯ Second Opinion
- ◯ Motor Vehicle Accident

Other: ____________________

Approximate date of onset: ______/______/________

What caused your injury, illness, pain? ____________________

What are you being seen for today? (Choose one):

	LEFT	RIGHT	BOTH
Shoulder	◯	◯	◯
Pelvis	◯	◯	◯
Arm	◯	◯	◯
Elbow	◯	◯	◯
Forearm	◯	◯	◯
Hand	◯	◯	◯
Wrist	◯	◯	◯
Finger	◯	◯	◯

	LEFT	RIGHT	BOTH
Hip	◯	◯	◯
Knee	◯	◯	◯
Thigh	◯	◯	◯
Lower Leg	◯	◯	◯
Foot	◯	◯	◯
Ankle	◯	◯	◯
Toe	◯	◯	◯

Other: ____________________

Should your condition require the physician to prescribe certain diagnostic tests, the following information is necessary to determine the appropriate procedure:

Are you or could you be pregnant? ◯ yes ◯ no

Are you claustrophobic (fear of being in small, closed areas)**?** ◯ yes ◯ no

Do you have:

- ◯ Pacemaker
- ◯ Neurostimulator
- ◯ Heart Valves
- ◯ Surgical Clips
- ◯ Artificial Joints / Limbs
- ◯ **Other metal objects in your body:** ____________________

Have you had any eye (i.e. artificial eye) **or ear** (i.e. inner ear implant) **surgery?** ◯ yes ◯ no

ALLERGIES

Please mark all allergies you have:

- ◯ **No Known Drug Allergies**
- ◯ Latex Allergy
- ◯ IV Contrast Allergy
- ◯ Penicillin
- ◯ Sulfa
- ◯ Erythromycin
- ◯ NSAIDS

Other: ____________________

Height: ____________________ **Weight:** ____________________

CURRENT SYMPTOMS

Are you currently experiencing any of the following symptoms? Mark all that apply. If no symptoms in a category, please mark "NONE."

GENERAL	fever ◯	chills ◯	weight loss ◯	**NONE** ◯
CARDIOVASCULAR		chest pain ◯	shortness of breath ◯	**NONE** ◯
GASTROINTESTINAL		liver disease ◯	heartburn ◯	
		nausea ◯	blood in stool ◯	**NONE** ◯
GENITOURINARY		painful urination ◯	blood in urine ◯	**NONE** ◯
NEUROLOGIC	headache ◯	weakness ◯	loss of consciousness ◯	**NONE** ◯
MUSCULOSKELETAL			painful, swollen joints ◯	**NONE** ◯
SKIN		rash ◯	itching ◯	**NONE** ◯
PSYCH	drug / alcohol addiction ◯	anxiety ◯	depression ◯	**NONE** ◯

Other: ____________________

MEDICATIONS

Are you currently taking medications? If yes, please list. ◯ yes ◯ no

Name of Medication	Dosage	Frequency

Name of Medication	Dosage	Frequency

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