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

Patient History

Please answer every question

STAFF: Handwritten responses 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

CURRENT PROBLEM

What is the reason for your visit today?

Weakness ◯ Unstable ◯
Pain ◯ Stiffness ◯ Popping / Grinding ◯
Numbness ◯ Swelling ◯ Other ◯

If you chose "Other", please specify: _____

Which body part(s) are affected?

Right ◯
Left ◯ Both ◯

Please specify which parts are affected: _____

Date of injury: _____ **Date of onset of symptoms:** _____

Where did the injury / symptoms occur?

At Home ◯ During Sports / Recreation ◯ At School ◯
At Work ◯ Car Accident ◯ Other ◯

If you chose "Other", please specify: _____

How did the injury / symptoms occur?

Previous Injury ◯
Sudden / Traumatic ◯ Gradual Onset ◯ Recurrence ◯
Lifting / Bending ◯ Injury Relating to a Fall ◯ Other ◯

If you chose "Other", please specify: _____

Have you had any previous medical care for this condition?

Yes ◯ No ◯

If "Yes", please specify: _____

Have you had any previous hospitalizations, surgeries, or serious injuries?

Yes ◯ No ◯

If "Yes", please specify when and what: _____

ALLERGIES

Write "yes" on the line if you are allergic to any of the following.
Write "yes" on the line next to "No Known Allergies" if applicable.

_____ Penicillin
_____ Sulfa
_____ Codeine
_____ Novacaine
_____ Aspirin
_____ Tetanus
_____ Iodine (By Mouth)
_____ Iodine (Topical)
_____ Iodine (Intravenous)
_____ Narcotics
_____ Antibiotics
_____ Shellfish / Seafood
_____ Latex / Rubber
_____ Pain Remedies
_____ Herbs
_____ Vitamins
_____ Food Allergies
_____ Metals
_____ **No Known Allergies**
_____ Other

If you chose "Other", please specify: _____

MEDICATIONS

Please list all medications, vitamins and herbal supplements you are currently taking.

Name of Medication	Dosage	Frequency

Name of Medication	Dosage	Frequency

YOUR MEDICAL HISTORY

Please indicate if YOU have a history of the following. If none, mark "NONE".

◯ Diabetes
◯ Arthritis
◯ Stroke
◯ Convulsions
◯ COPD
◯ Gout
◯ Kidney Failure / Dialysis
◯ Liver Disease / Hepatitis
◯ Bleeding Tendency
◯ Pacemaker / Defibrillator
◯ Hereditary Defects
◯ Heart Trouble
◯ High Blood Pressure
◯ Cancer
◯ Other
◯ **NONE**

If you chose "Cancer", please specify: _____

If you chose "Other", please specify: _____

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SOCIAL HISTORY

What is your cigarette smoking status?

Current (Every Day) ◯ Current (Some Days) ◯ Previous ◯ Never ◯

How many packs of cigarettes do you (or did you) smoke daily?

<½ ◯ ½ ◯ 1 ◯ 1 ½ ◯ 2 ◯ >2 ◯

How many cigars / pipes do you (or did you) smoke daily?

<½ ◯ ½ ◯ 1 ◯ 1 ½ ◯ 2 ◯ >2 ◯

Do you chew tobacco? Current (Every Day) ◯ Current (Some Days) ◯ Previous ◯ Never ◯

Do you use recreational drugs? Yes ◯ No ◯

Do you drink alcoholic beverages? Yes ◯ No ◯

If yes, how often?

Patient Drinks Socially, Having < 1 Drink per Day ◯ Rarely ◯ Weekly ◯ Daily ◯

Marital status: Single ◯ Married ◯ Divorced ◯ Separated ◯ Widow/er ◯

Do you have excessive exposure at home or work to any of the following? (mark all that apply)

Fumes ◯ Dust ◯ Solvents ◯ Airborne Particles ◯ Noise ◯ **NONE** ◯

OSTEOPOROSIS EVALUATION

Please mark all items that apply to you. If none, mark "NONE".

- Female ◯
- Underweight ◯
- Smoking ◯
- Habitual Low Calcium ◯
- Height Loss in the Past Year ◯
- Menopause or Surgical Removal of Ovaries ◯
- Alcohol Consumption (3 Drinks per Day) ◯
- Excessive Carbonated Drink Consumption (4 or More a Day) ◯
- Have a Family Member with a Hip Fracture by Age of 50 ◯
- Inactive (Less than 20 Min. of Weight Bearing Exercise 3 Days / Week) ◯
- **NONE** ◯

INFECTIOUS DISEASES

Do you or have you had any infectious diseases?

Please mark all items that apply to you. If none, mark "NONE".

- ◯ HIV / AIDS
- ◯ Hepatitis A
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ MRSA
- ◯ Tuberculosis
- ◯ Sexually Transmitted Diseases
- ◯ Other
- ◯ **NONE**

If you marked Tuberculosis, when did you contract it?

_____

If you chose "Other", please specify:

_____

FAMILY MEDICAL HISTORY

Mark all illnesses that any FAMILY MEMBER has had.

◯ **FAMILY HISTORY Unknown**

	Father	Mother	Brother(s)	Sister(s)	Child(ren)	MOTHER'S SIDE Grandmother	MOTHER'S SIDE Grandfather		FATHER'S SIDE Grandmother	FATHER'S SIDE Grandfather
Diabetes	◯	◯	◯	◯	◯	◯	◯		◯	◯
Lung Disease	◯	◯	◯	◯	◯	◯	◯		◯	◯
Alcoholism	◯	◯	◯	◯	◯	◯	◯		◯	◯
Drug Abuse	◯	◯	◯	◯	◯	◯	◯		◯	◯
Back Problem	◯	◯	◯	◯	◯	◯	◯		◯	◯
Cancer	◯	◯	◯	◯	◯	◯	◯		◯	◯
Heart Disease	◯	◯	◯	◯	◯	◯	◯		◯	◯
Arthritis	◯	◯	◯	◯	◯	◯	◯		◯	◯
Carpal Tunnel Syndrome	◯	◯	◯	◯	◯	◯	◯		◯	◯

Other: *Please specify* _____

◯ **NONE**

Signature: _____ **Date:** _____