

HEALTH HISTORY FORM

Patient Name _____ **Birth Date** _____ **Date** _____

Female Male Age _____ Height _____ Weight _____ Dominant Hand R L

What is the reason for this visit Pain Numbness Weakness Swelling Stiffness

Other _____

How long ago did your symptoms start _____ days weeks months years

Have you had a problem like this before Y N

Who requested that you visit this office _____

What body part is involved? *Mark below*

<input type="checkbox"/> Neck: Radiates into: <input type="checkbox"/> R arm <input type="checkbox"/> L arm <input type="checkbox"/> None
<input type="checkbox"/> Back: Radiates into: <input type="checkbox"/> R leg <input type="checkbox"/> L leg <input type="checkbox"/> None
Shoulder: <input type="checkbox"/> R <input type="checkbox"/> L
Arm: <input type="checkbox"/> R <input type="checkbox"/> L
Elbow: <input type="checkbox"/> R <input type="checkbox"/> L
Wrist: <input type="checkbox"/> R <input type="checkbox"/> L
Hand: <input type="checkbox"/> R <input type="checkbox"/> L
Finger: <input type="checkbox"/> R: 1, 2, 3, 4, 5 <input type="checkbox"/> L: 1, 2, 3, 4, 5
Hip: <input type="checkbox"/> R <input type="checkbox"/> L
Knee: <input type="checkbox"/> R <input type="checkbox"/> L
Pelvis: <input type="checkbox"/> R <input type="checkbox"/> L
Leg: <input type="checkbox"/> R <input type="checkbox"/> L
Ankle: <input type="checkbox"/> R <input type="checkbox"/> L
Foot: <input type="checkbox"/> R <input type="checkbox"/> L
Toe: <input type="checkbox"/> R: 1, 2, 3, 4, 5 <input type="checkbox"/> L: 1, 2, 3, 4, 5

Check one box which best describes how your problem started. <input type="checkbox"/> No Injury (Onset was: <input type="checkbox"/> Gradual or <input type="checkbox"/> Sudden) <input type="checkbox"/> Injury <input type="checkbox"/> Injury at work Date _____ <input type="checkbox"/> Work Related (Without Injury) <input type="checkbox"/> Auto Accident Date _____ Briefly describe Injury: _____ _____ _____ _____ _____ _____

On a scale of 0 to 10 (10 is the worst) how severe is your pain? <p style="text-align: center;">0 1 2 3 4 5 6 7 8 9 10</p>

Please answer questions below regarding your injury:

Do you have:

Swelling Bruising Numbness Tingling Weakness Loss of control of bowel or bladder

Is your pain (circle all that apply) Sharp Dull Stabbing Throbbing Aching Burning

The pain is: constant Comes and goes. Does the pain wake you up at night Y N

Are your symptoms: Getting better Getting worse Unchanged

What makes your symptoms worse?

Standing Walking Lifting Exercise Lying in bed

Bending Squatting Kneeling Stairs Sitting Coughing Sneezing

What makes your symptoms better? Rest Ice Heat Other

What medications are you taking or have taken for this problem? _____

Did you have any imaging studies? Y N

If Yes: X-RAY MRI CAT scan Bone Scan Nerve test

Have you had any previous treatments for this problem? (circle those that apply)

Injection Brace Surgery Physical Therapy Cane/Crutch

Were you seen in the E.R. for this problem? Y N

Which E.R. _____ Date _____

Have you already had surgery for a problem in this same area either recently or in the past? Y N

Procedure _____ Surgeon _____ Hospital _____ Date _____

Current work status?

Regular Light Duty Not working due to this problem Disabled Retired

When is the last date you worked your regular job? _____

Are you currently receiving or plan to apply for: Disability Workman's Comp Unemployment

Patient Name _____

D.O.B. _____

Past Medical History

Have you ever had, or are currently treated for any of the following: *Circle those that apply*

- | | | | |
|-----------------------|-------------------|----------------|-------------|
| Arthritis | Cancer | Acid Reflux | Other _____ |
| Gout | Stroke | Fibromyalgia | |
| **Diabetes | Hepatitis | Osteoporosis | |
| High Blood Pressure | Thyroid Disease | Liver Disease | |
| Elevated Cholesterol | Asthma | Stomach Ulcers | |
| Restless Leg Syndrome | AIDS or HIV | Anemia | |
| Tuberculosis | Bleeding Disorder | Neuropathy | |
| Heart Disease | Kidney Disease | Blood Clots | |
- **Diabetes: Diet controlled Oral medications Insulin *circle one* Type 1 or Type 2

Previous Hospitalizations:

Previous Surgeries:

Medications (Include non-prescription):

Allergies(Please list): Drug, Latex, etc.

You may receive Anti-inflammatory pills as a result of this visit. Has any physician instructed you NOT to take anti-inflammatory medications? Y N,

If yes, why _____

Have you ever had a reaction to Anesthesia? Y N

Do you have any artificial parts? Y N

Have you experienced any of the following symptoms in the last 6 months?

Circle all those that apply and explain in space to the right

- | | | |
|--------------------|----------------------|------------------------------|
| Weight loss/gain | Palpitations | Headache |
| Frequent fevers | Acid Reflux | Depression |
| Dizziness | Multiple joint aches | Cough |
| Seizures | Swelling of joints | Weakness |
| Loss of appetite | Shortness of breath | Drug/Alcohol addiction |
| Changes in vision | Painful urination | Sleep Disorder |
| Hearing loss | Blood in urine | Easy Bleeding/ Easy Bruising |
| Trouble swallowing | Frequent Rashes | Loss of consciousness |
| Hoarseness | Skin Ulcers | Anemia |
| Chest pain | Psoriasis | Blood in stool |

Patient Name _____ D.O.B. _____

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Family History

Have any of your direct relatives (father, mother, siblings, children) had any of the following conditions:

Rheumatoid Arthritis Hypertension Diabetes Heart Disease Other _____

Social History

Use of tobacco Y N If yes, **Packs per day** _____ **for** _____ **years**

Use of alcohol Never Rarely Moderately Daily

Marital History: M S D W

Occupation _____ Employer _____

Do you like your job? Y N

Do you plan to be working 6 months from now? Y N

Signature of patient/parent/guardian

Date

MD/PA Initials

Review # 1

Review #2