PATIENT HISTORY FORM

Today's Date: _____/_____/ ____Social Security No.: _____Date of Birth: _____/ _____/_____Age: _____

Last Name: _____First Name:_____MI: _____Ht:_____Wt:_____

Chief Complaint: What is the main reason for your visit today? _____

HISTORY OF PRESENT ILLNESS

Date of Accident or Date Symptoms Began:
_____/_____/ _____

Location of the problem: Rt Lt Both

_____

Was this a work related accident?	Yes	No
Was this an auto accident?	Yes	No
Recreational or school athletic injury?	Yes	No
Accident in your home?	Yes	No
Accident other than above?	Yes	No

Explain: _____

Are you currently working? Yes No

If yes, are you working: full duty or limited duty

List any other doctors you have seen for this problem:

_____

_____

List any previous tests or procedures for this problem:

_____

_____

_____

Does anything help or make the problem worse?

Moving around Standing up Lying on my side

Other _____

Explain Injury or Illness: _____

_____

_____

_____

Describe the symptoms you are having: _____

_____

_____

_____

Is anything else occurring at the same time?

❑ Yes ❑ No If yes, please explain.

Nausea Rash Headaches Fatigue Wt Loss/Gain

Diarrhea Fever Bloating Bleeding

Other _____

How long does the problem last?

30 minutes 1 hour It is always there

Other _____

Is the problem constant or variable?

Dull then Sharp Very sharp then leaves Always there

Other: _____

Does the problem interfere with your normal functions?

❑ Yes ❑ No If yes, please explain

_____

PAST MEDICAL, FAMILY & SOCIAL HISTORY

List any personal illness:

_____

_____

_____

_____

Check Current Immunizations:

❑ Flu Approx. Date_____

❑ Tetanus Approx. Date_____

❑ Pneumonia Approx. Date_____

List any surgeries and date occurred:

_____

_____

_____

_____

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.):

	Relation
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any drug allergies? Yes No (If Yes, please explain)

_____ _____

_____ _____

Please list all medications you are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do/did you smoke? ❑ Yes ❑ No

If yes, how much?_____

If yes, how long?_____

Do/did you drink? ❑ Yes ❑ No

If yes, how much? _____

Are you right or left handed? Rt. Lt

Do you exercise regularly? ❑ Yes ❑ No

If yes, how much?_____

If age 55 or older, have you ever had a Bone Density Test? ❑ Yes ❑ No