

PATIENT MEDICAL HISTORY

NAME: _____ AGE: _____ GENDER: M / F

HEIGHT: _____ WEIGHT: _____

MARITAL STATUS: Married Single Other Right-handed Left-handed

PCP DR: _____ PHONE#: _____ FAX #: _____

REF. DR: _____ PHONE#: _____ FAX #: _____

CHIEF COMPLAINT: RIGHT LEFT _____ (i.e. right knee, left knee)

My medical problem ***IS NOT*** related to an injury. When did your symptoms begin? _____

My medical problem ***IS*** related to a work injury. Date of Injury: _____

My medical problem ***IS*** related to a motor vehicle accident. Date of accident: _____

Occupation: _____ Full-Time Student Retired

• Are you currently working? YES NO-Last day: _____ Unemployed Disabled

○ Reason not working: _____

PAIN AND SYMPTOMS OF CURRENT CHIEF COMPLAINT

Numbness/Tingling

Predominantly leg pain

Weakness

Swelling

Catching/locking

predominantly back pain

Radiating Pain

Giving Way Episodes

Bowel/bladder changes

Pain while walking

Pain climbing stairs

Pain while standing

Trouble sleeping

Popping/Clicking

Pain while sitting

Limited Range of motion

Pain while lying down

TREATMENT YOU HAVE HAD FOR CURRENT INJURY

Physical Therapy

Bonescan

CT/Myelogram

Epidural Steroid Injections

Discogram

Muscle Relaxers

Oral Steroids

Rest

MRI

EMG

Pain Medication

Chiropractic Treatment

Cortisone Injections

Anti-inflammatory meds

X-rays

Nerve Root Blocks

Splinting/Bracing

Casting

SOCIAL HISTORY

Do you use tobacco products? YES NO (cigarettes, chewing tobacco/cigars)

Do you drink alcohol? YES NO

Is there any chance you could be pregnant? YES NO Date of last menstrual period? _____

Please list **ALL Medications** with dosages (Prescription, Vitamins, Herbal) NONE See attached list:

Please list **ALL Allergies** to any Medications, Latex, Tapes, Etc.: NONE

Please list **ALL types of Surgeries** you have had & the Year- NONE

Please mark for any medical conditions YOU suffer from:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV Infection | <input type="checkbox"/> Liver Disease/Jaundice | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bladder/Prostate Problems | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lupus | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Polio | <input type="checkbox"/> Weakness or Paralysis |
| <input type="checkbox"/> Frequent headache/Migraine | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety or nervousness |
| <input type="checkbox"/> History of Gout | <input type="checkbox"/> Thyroid Problems | | |

Please mark for any conditions YOUR FAMILY suffers from:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV Infection | <input type="checkbox"/> Liver Disease/Jaundice | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bladder/Prostate Problems | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lupus | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Polio | <input type="checkbox"/> Weakness or Paralysis |
| <input type="checkbox"/> Frequent headache/Migraine | | | |

Please mark any symptoms YOU are currently experiencing:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Weight loss or gain | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Urinary frequency | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Vision Correction | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Seizures | |

The above information is completed to the best of my knowledge

Patient Signature: _____

Date: _____