PATIENT HEALTH HISTORY

Today's Date:_____ **Patient's Date of Birth:**_____

Patient Name:_____ **Age:**_____ **Sex:** ❑ M ❑ F

Height:_____ **Weight:**_____ lbs **Dominant hand** ❑ Right ❑ Left ❑ Both

Referring Physician:_____

What are you being seen today for?_____

How long have you had this problem or when did the injury occur?_____

Please describe your symptoms ❑ Sharp Pain ❑ Dull Ache ❑ Numbness ❑ Tingling ❑ Weakness

❑ Locking ❑ Catching ❑ Popping ❑ Grinding ❑ Decreased Motion ❑ Decreased Strength

On a scale of 0-10 (10 is the worst) how severe is the pain? _____

What activities make your pain worse?_____

How are you able to relieve your pain?_____

Do you take medications for this problem? ❑ Yes ❑ No

Have you had an injection for this problem? ❑ Yes ❑ No

Have you tried formal physical therapy for this problem? ❑ Yes ❑ No

What tests have you had for this problem? ❑ X-ray ❑MRI ❑CT Scan ❑other _____ **Where**? _____

Have you had surgery on this body part before? ❑ Yes ❑ No **When?**_____

Surgery performed: _____

Work related Injury? ❑ Yes ❑ No **Auto related Injury?** ❑ Yes ❑ No

PAST MEDICAL HISTORY – Have you ever been treated for any of the following conditions?

❑ AIDS/HIV	❑ Chronic Fever	❑ Hemophilia	❑ Pacemaker
❑ Anemia	❑ Chronic Leg Weakness	❑ Hepatitis A	❑ Previous Broken Bones
❑ Anesthesia Reaction	❑ Cirrhosis of Liver	❑ Hepatitis B	❑ Psoriasis
❑ Aneurysm clips	❑ Claustrophobia	❑ Hepatitis C	❑ Psoriatic Arthritis
❑ Angina	❑ COPD	❑ High Blood Pressure	❑ Rheumatoid Arthritis
❑ Anxiety	❑ Depression	❑ High Cholesterol	❑ Seizures/Epilepsy
❑ Asthma	❑ Diabetes	❑ Irregular Heart Beat	❑ Sense of Imbalance
❑ Bladder Infection	❑ Emphysema	❑ Kidney Disease	❑ Shingles
❑ Bleeding Disorder	❑ Excessive Fatigue	❑ Kidney Stones	❑ Sleep Apnea
❑ Blood Clot/DVT/PE	❑ Excessive Weight Loss	❑ Lymes Disease	❑ Snoring
❑ Blood Transfusion	❑ Fainting Spells	❑ MRSA Infection	❑ Strokes
❑ Bronchitis	❑ Fibromyalgia	❑ Menieres Disease	❑ Substance Abuse
❑ Cancer	❑ Gout	❑ Migraines	❑ Thyroid Disease
❑ Chronic Arm Weakness	❑ Heart Attack/MI	❑ Obesity	❑ Tuberculosis/TB
❑ Chronic Back Pain	❑ Heart Disease	❑ Osteoarthritis	❑ Ulcers
❑ Chronic Pain	❑ Heart Failure/CHF	❑ Osteopenia	❑ Urinary Tract Infections
❑ Chronic Cough	❑ Heart Murmur	❑ Osteoporosis	❑ Vascular Disease

❑ Other_____

PAST SURGICAL HISTORY – Please list <u>all</u> of your previous surgeries.

SURGERIES (with dates if known)

ALLERGIES – Please list all medications that you are allergic to.

MEDICATION ALLERGY	ALLERGIC REACTION

Are you allergic to latex, metal, or tape? ❑ Yes ❑ No Please describe:_____

CURRENT MEDICATIONS – Please list all medications that you take including any supplements or vitamins.

MEDICATIONS (with dosage if known)

SOCIAL HISTORY:

Do you use tobacco products (❑ Cigars ❑ Pipe ❑ VAPE ❑ Chew**)?** ❑ Yes ❑ No **How Much?** _____

❑ I quit smoking_____years ago

Do you drink alcohol? ❑ Yes ❑ No **How Much?** _____

What is your occupation?_____

FAMILY HISTORY – Does a family member (parent, sibling, or grandparent) have a history of the following?

❑ Diabetes ❑ Heart Disease ❑ Cancer ❑ Rheumatoid Arthritis ❑ Osteoarthritis ❑ Gout

_____ _____ _____

Patient/Parent/Guardian Signature Interpreter's Name (please print) Date