

PATIENT HISTORY

NAME: _____ AGE _____ HEIGHT _____ WEIGHT _____

REFERRING DOCTOR: _____ You are: Right-handed Left-handed

Primary Care Physician (PCP): _____ PCP Phone Number: _____

REASON FOR VISIT: _____

How long have you had the current problem? _____ Date of Injury _____

The current problem is the result of a(n): Check all that apply: Car Accident Work Accident Other _____

Prior testing or treatment of the problem: Check all that apply: MRI Xrays CT Scan Myelogram EMG

Physical therapy, for how long: _____ Epidural Steroids Other treatment: _____

MEDICAL HISTORY: Check and/or Circle all that apply: Recent physical? Yes / No How long ago? _____

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney or Renal Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Diagnosed Migraines |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Urinary Disorder *explain | <input type="checkbox"/> DVT or Phlebitis | <input type="checkbox"/> Headaches (not occasional ones) |
| <input type="checkbox"/> Bypass or <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Heart Valve Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Bleeding /Blood Disorder | <input type="checkbox"/> Memory Problems |
| <input type="checkbox"/> Mitral Valve Prolapse (MVP) | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Difficulty with Speech |
| <input type="checkbox"/> Other Heart Condition *explain | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Bowel Disorder *explain | <input type="checkbox"/> Nausea or Vomiting |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other Immune Disorder | <input type="checkbox"/> Breast Disease | <input type="checkbox"/> Double vision <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Lung Disease *explain | <input type="checkbox"/> Cancer *explain | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes- <input type="checkbox"/> Insulin dependent? | <input type="checkbox"/> Stroke (CVA) or <input type="checkbox"/> TIA | <input type="checkbox"/> History of MRSA | <input type="checkbox"/> Other *explain |

* Explanation of any **starred** _____
 Medical Condition above: _____

LIST ALL PRIOR SURGERIES	YEAR

LIST ALL MEDICATION, incl. non-prescription

ALLERGIES TO MEDICATIONS:
<input type="checkbox"/> Latex Allergy
<input type="checkbox"/> NONE KNOWN
<input type="checkbox"/> YES, LIST ALL:

Have you ever had problems with anesthesia or complications following any surgery? No Yes If yes, please explain: _____

SOCIAL HISTORY: Marital Status: Single Married Divorced Widowed

Occupation: _____ Sports/Activities: _____

Do you live alone? Yes No Do you have children @ home? Yes No Age(s): _____

Do you smoke?
 No, I have never smoked.
 No, I quit _____ years ago
 Yes, I smoke _____ packs per day for the past _____ years.
 Cigars _____ per week _____ per month
 History of substance abuse, explain: _____

Do you drink alcohol?
 No, never Rarely
 1 or more times a month
 1 or more times a week
 Daily Explain: _____

The above information is accurate to the best of my knowledge. I understand that this information, including alcohol/substance use and HIV/AIDS information is part of my medical chart and may be released as such upon authorized request.

SIGNATURE: _____

DATE: ____/____/____