

Patient Name: _____
Birthdate ____/____/____
Today's Date ____/____/____

PATIENT HEALTH HISTORY

PLEASE COMPLETE PAGE 1 AND 2

Physician you are seeing today _____

Who referred you to our office? _____ Clinic: _____

PAST MEDICAL HISTORY		Do you have a personal history of any of the following: (none or circle)
General	<input type="checkbox"/> None	Cancer Diabetes Thyroid disease Delayed wound healing Malignant hyperthermia Hepatitis AIDS/HIV Difficulty with anesthesia
Heart/Circulation	<input type="checkbox"/> None	MI/Heart Attack Blood Clots High Blood Pressure Stroke Abnormal Rhythm Pacemaker Bleeding disorders
Lungs	<input type="checkbox"/> None	Asthma Emphysema Oxygen dependence Bronchitis
Gastrointestinal	<input type="checkbox"/> None	Ulcers Appendectomy Gallbladder surgery Crohn's Disease Reflux/GERD
Neuro/Psych	<input type="checkbox"/> None	Depression Anxiety disorder Schizophrenia Seizures Chemical Dep
Musculoskeletal	<input type="checkbox"/> None	Arthritis Gout Fracture Ligament injury/Sprain Fibromyalgia Previous Orthopedic Surgery Bone joint infections
Other		List:

HOSPITALIZATIONS/SURGERIES	YEAR
List all previous hospitalizations and/or surgeries	<input type="checkbox"/> None

MEDICATIONS	
List any medications you are taking and why. Include herbs, inhalers, non-prescription medications <input type="checkbox"/> None	
Dosage/Frequency	Dosage/Frequency

To your knowledge, have you ever taken Prednisone/Cortisone by mouth? yes no don't know

ALLERGIES	
List any medications you are sensitive to and the reaction	<input type="checkbox"/> None

Have you ever had a reaction to: eggs shellfish/iodine latex rubber

Do you use tobacco in any form? yes no Quit # ____ years If yes, # per day ____ # of years ____
 Do you drink alcohol? yes no Quit # ____ years If yes, # per week ____ # of years ____
 Have you ever used recreational drugs? yes no List:

FAMILY HISTORY (Grandparents, parents, siblings)	
Do you have a family history of any of the following? <input type="checkbox"/> None	
<input type="checkbox"/> diseases of muscles, bones, or nervous system	<input type="checkbox"/> difficulty with anesthesia
<input type="checkbox"/> arthritis <input type="checkbox"/> rheumatoid <input type="checkbox"/> osteoarthritis	<input type="checkbox"/> diabetes
<input type="checkbox"/> bleeding disorders <input type="checkbox"/> blood clots	<input type="checkbox"/> infectious diseases

If yes, please explain:

WORK / SOCIAL HISTORY

Children yes no How many? _____ Ages _____
 Do you live alone with family assisted living nursing home other
 Are you currently working? yes no If no, when did you last work? _____
 Occupation: _____ Employer _____ How long? _____

Is your regular work? Heavy Medium Light Sedentary
 Are you currently on any work restrictions? yes no If yes, what are they? _____

Do you exercise or participate in sports on a regular basis? yes no If yes, Please explain:

REVIEW OF SYSTEMS (check None or circle any that apply)

General	<input type="checkbox"/> None	Recent unexplained weight loss or gain fatigue fever chills night sweating risk factors HIV/AIDS
Eyes	<input type="checkbox"/> None	double vision blurred vision blind spots glasses/contact lenses glaucoma cataracts legally blind
Ears/Nose/Throat	<input type="checkbox"/> None	ringing in ears difficulty hearing use hearing aid deaf (read lips; ASL) frequent nose bleeds hoarseness dry mouth sinus problems dentures/partial plate/braces/caps
Lungs	<input type="checkbox"/> None	chronic cough wheezing shortness of breath pneumonia coughing blood
Heart/circulation	<input type="checkbox"/> None	chest pain leg swelling hands/feet always cold leg cramps varicose veins easy bruising
Gastrointestinal	<input type="checkbox"/> None	stomach ulcers problems with bowel movements heartburn nausea swallowing problems
Genitourinary	<input type="checkbox"/> None	incontinence painful urination blood in urine trouble starting stream
Reproductive	<input type="checkbox"/> None	pregnant possible pregnancy menopause prostate problems
Musculoskeletal	<input type="checkbox"/> None	joint pain joint swelling stiffness arthritis gout muscle or tendon injuries fractures childhood deformities or braces
Skin	<input type="checkbox"/> None	rashes lumps sores color changes change in hair or nails skin tears easily difficulty healing skin
Neurological	<input type="checkbox"/> None	numbness or tingling weakness pins and needles tremors/shaking seizures dizziness fainting
Endocrine	<input type="checkbox"/> None	thyroid heat or cold intolerance when others are comfortable excessive thirst excessive sweating
Psychiatric	<input type="checkbox"/> None	depression anxiety excessive stress nervousness panic attacks

Patient Signature: _____ **Date** _____

Physician/Non-Physician Signature _____ **Date** _____

UPDATES OR CHANGES

Date	Remarks	Initial