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Medical History

Patient Name: ____ **DOB: _____________** **Date: _____________**

Height: _____ft _____in **Weight: _________lbs**

Preferred Pharmacy and Location: ____

Primary Care Physician: ____

Referring Physician: ____

We are now required to collect Ethnicity, Race, and Language. You may decline to specify this information.

Ethnicity:
____ Non-Hispanic / Latino
____ Hispanic / Latino
____ Decline to specify

Race:
____ American Indian / Native Alaskan
____ Asian
____ Black / African American
____ Native Hawaiian / Pacific Islander
____ White
____ Other:_________________________

____ Decline to specify

Preferred Language: _________________________

Do you have allergies to any medications? **____ Yes** **____ No** (If yes, please specify):

Medication: _______________________ Allergic Reaction: ______________________
Medication: _______________________ Allergic Reaction: ______________________
Medication: _______________________ Allergic Reaction: ______________________

Please list any medications you are currently taking on a regular basis, with the frequency. **____ None**

Medication:	**Frequency:**	**Reason:**
___________________	___________________	___________________
___________________	___________________	___________________
___________________	___________________	___________________
___________________	___________________	___________________
___________________	___________________	___________________
___________________	___________________	___________________
___________________	___________________	___________________

Patient / Legal Guardian Signature: ____ **Date:** _______________

Please specify which body part you are being seen for today: ___________________________________

____ Right ____ Left ____ Bilateral (both sides)

How did this injury occur?____ Injury ____ Accident ____ Sport ____ No Injury

- Date of injury: _____________
- Did this injury occur at work? ____ Yes ____ No
- Date of onset pain: _____________
- Date of Auto Accident: _____________
- Description of injury: ____
  ____
  ____

Have you had a problem like this before? ____ Yes____ No

Have you been seen in the E.R. for this problem? ____Yes ____ No

If yes, please specify which E.R.: ____

What testing have you had performed for this problem?

____ X-Rays ____ MRI ____ CAT/CT Scan ____ Bone Scan ____ Nerve Study (EMG/NCV)

On a scale of 0-10, 10 being the most pain you can imagine, how severe is your pain? _______________

Is your pain: ____ constant ____ intermittent (comes and goes)

Does the pain wake you from sleep? ____ Yes ____ N

Please circle all that apply:

I experience: Swelling Bruising Numbness Tingling Weakness

Loss of bladder or bowel control Locking Catching Giving away Stiffness

Pain Other: ____

What makes the pain worse: Standing Kneeling Sitting Coughing Sneezing

Bending Laying in bed Walking Lifting Twisting

Family History:

Have any direct family members experienced any of the following medical problems:

Father: ___Diabetes ___Anesthesia Problems ___High Blood Pressure ___Bleeding Problems ___ Rheumatoid Arthritis

Mother: ___Diabetes ___Anesthesia Problems ___High Blood Pressure ___Bleeding Problems ___ Rheumatoid Arthritis

Sibling(s): ___Diabetes ___Anesthesia Problems ___High Blood Pressure ___Bleeding Problems ___ Rheumatoid Arthritis

Social History:

Do you use tobacco? ___Yes ___No ___Quit If yes, packs per day _____ If quit, when _____________

Have you been informed of smoking risk? ___Yes ___No

Alcohol use? ___Yes ___No ___Quit

Marital History: ___Married ___Divorced ___Widowed

Patient / Legal Guardian Signature: ____ Date: ________________

Are you currently working? ___Yes ___No ___Retired ___Disabled If disabled, when did you last work? _____________

Are you currently on any work restrictions? ___Yes ___No If yes, please specify: ____

____

Occupation: __________________________________ Employer: _________________________________ Student: _______

Past Medical History:

Please list all surgeries and the year they were performed. ___None

____

____

____

____

____

Do you have a personal history of any of the following conditions: ___None

Condition	Y/N		Condition	Y/N
Aids/HIV	__Y __N		High Cholesterol	__Y __N
Anemia	__Y __N		Hypertension	__Y __N
Anxiety	__Y __N		Kidney Disease	__Y __N
Arthritis	__Y __N		Liver Disease	__Y __N
Asthma	__Y __N		Migraines	__Y __N
Bleeding disorders	__Y __N		Orthotics	__Y __N
Blood Clots	__Y __N		Pacemaker	__Y __N
Blood Transfusion	__Y __N		Peripheral Vascular Disease	__Y __N
COPD	__Y __N		Pulmonary Embolism	__Y __N
Cancer	__Y __N	Type: _____________	Rheumatoid Arthritis	__Y __N
Coronary Artery Disease	__Y __N		Seizures / Epilepsy	__Y __N
Diabetes	__Y __N	Type: _____________	Stroke	__Y __N
Gout	__Y __N		Thyroid Disease	__Y __N
Heart Attack (MI)	__Y __N		Tuberculosis	__Y __N
Hepatitis	__Y __N	Type: _____________	Ulcers	__Y __N
Hernia	__Y __N			

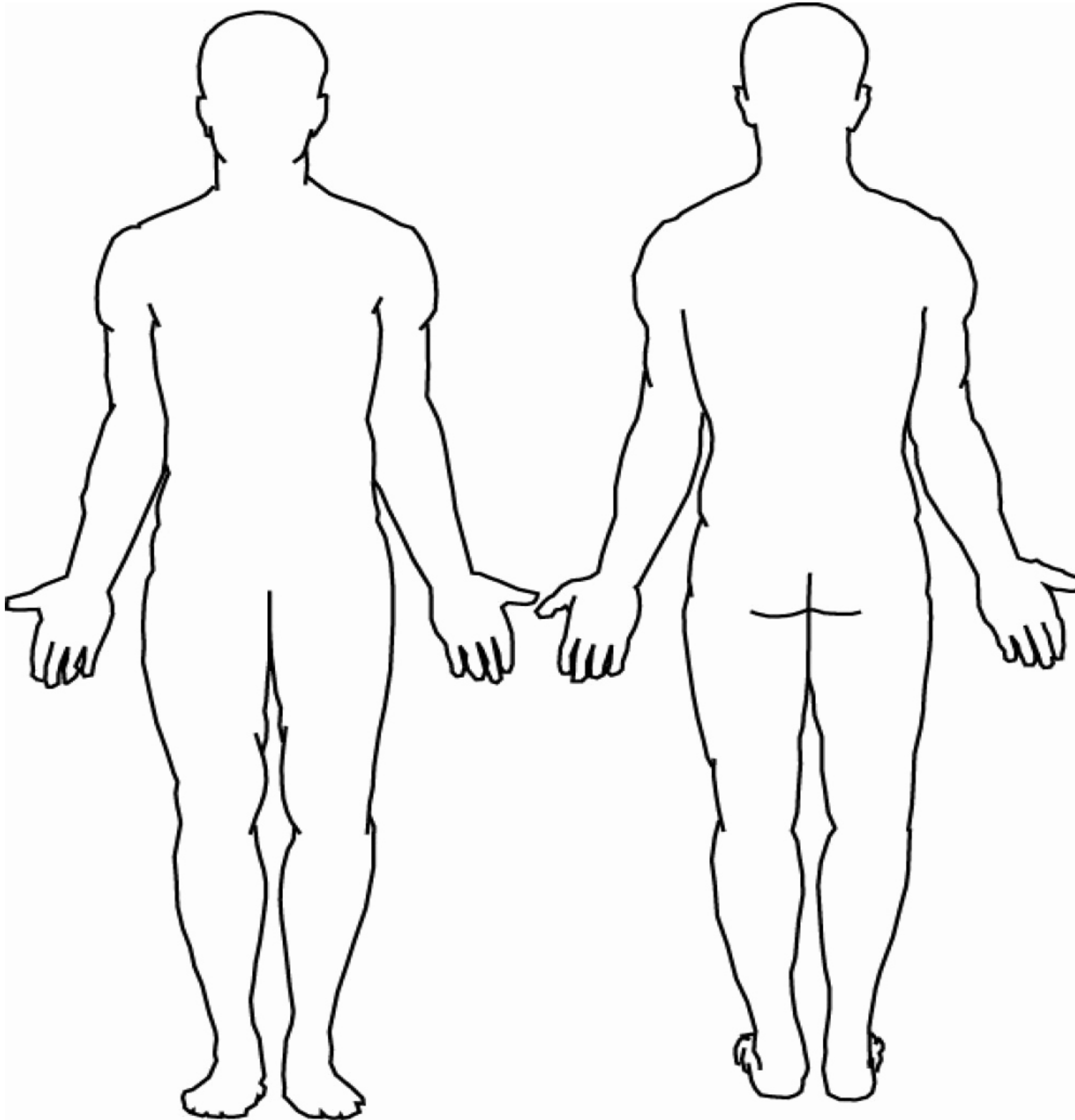
Patient / Legal Guardian Signature: ______________________________ **Date:** ______________

Patient Pain Drawing

<u>Where is your pain now?</u>

Please mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation, including all affected areas.

Aching	Numbness	Pins and needles	Burning	Stabbing
^^^	**- - -**	**OOO**	**XXX**	**///**



How bad is your pain now?

Please mark with an → on the body form where the pain is the worst now.

Please rate your current pain on the scale below:

No Pain ____ **Worst Possible Pain**