



# New Patient History Form (page 1 of 3)

## Background Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_  
Date of Birth: \_\_\_ / \_\_\_ / \_\_\_\_\_ Age: \_\_\_ Occupation: \_\_\_\_\_ Sex:  Male  Female  
Marital Status:  Single  Married  Widowed  Divorced Weight: \_\_\_ lbs. Height: \_\_\_ ft. \_\_\_ in.

## Today's Visit

Today's Date: \_\_\_ / \_\_\_ / \_\_\_\_\_  
Reason for Today's Visit: \_\_\_\_\_  
Are you here for a work related injury:  Yes  No If yes, is litigation pending:  Yes  No

## Current Medications

List Any Known Drug Allergies: \_\_\_\_\_

Medication	Dose	Frequency	Estimate how long you have taken medication

Other Medications: \_\_\_\_\_

## Past Medical History (please check all appropriate boxes)

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV                    | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Stomach ulcers       |
| <input type="checkbox"/> Alcoholism                  | <input type="checkbox"/> Crohn's disease         | <input type="checkbox"/> Ulcerative Colitis        | <input type="checkbox"/> Psoriasis            |
| <input type="checkbox"/> Alzheimer's                 | <input type="checkbox"/> Degenerative arthritis  | <input type="checkbox"/> Juv. rheumatoid arthritis | <input type="checkbox"/> Vascular disease     |
| <input type="checkbox"/> Low blood count             | <input type="checkbox"/> Depression              | <input type="checkbox"/> Kidney disease            | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Chest pain                  | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Liver disease             | <input type="checkbox"/> Scoliosis            |
| <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Drug abuse              | <input type="checkbox"/> Lyme disease              | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Blood clot              | <input type="checkbox"/> Migraines                 | <input type="checkbox"/> Sleep Apnea          |
| <input type="checkbox"/> Afib (irregular heart rate) | <input type="checkbox"/> Fibromyalgia            | <input type="checkbox"/> Multiple Sclerosis        | <input type="checkbox"/> Lupus                |
| <input type="checkbox"/> Enlarged prostate           | <input type="checkbox"/> Gallbladder disease     | <input type="checkbox"/> Heart Attack              | <input type="checkbox"/> Spinal Stenosis      |
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Esophageal reflux       | <input type="checkbox"/> Obesity                   | <input type="checkbox"/> Back Arthritis       |
| <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Gout                    | <input type="checkbox"/> Osteoarthritis            | <input type="checkbox"/> Thyroid disease      |
| <input type="checkbox"/> Heart failure               | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Osteoporosis              | <input type="checkbox"/> Heart valve disease  |
| <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Parkinson's disease       |   |

Other past medical history: \_\_\_\_\_

# New Patient History Form (page 2 of 3)

**Past Surgical History (please check all appropriate boxes)**

<input type="checkbox"/> ACL surgery	<input type="checkbox"/> Back surgery	<input type="checkbox"/> Hernia repair	<input type="checkbox"/> Rotator cuff surgery
<input type="checkbox"/> Angioplasty	<input type="checkbox"/> Heart bypass surgery	<input type="checkbox"/> Hip surgery	<input type="checkbox"/> Bowel resection
<input type="checkbox"/> Heart stents	<input type="checkbox"/> Heart valve surgery	<input type="checkbox"/> Hip replacement	<input type="checkbox"/> Thyroid surgery
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Carpal tunnel surgery	<input type="checkbox"/> Knee replacement	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Ankle arthroscopy	<input type="checkbox"/> Cataract surgery	<input type="checkbox"/> Laminectomy	<input type="checkbox"/> C-section
<input type="checkbox"/> Elbow arthroscopy	<input type="checkbox"/> Gallbladder surgery	<input type="checkbox"/> LASIK	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Knee arthroscopy	<input type="checkbox"/> Colon resection	<input type="checkbox"/> Meniscus surgery	<input type="checkbox"/> Breast surgery
<input type="checkbox"/> Hip arthroscopy	<input type="checkbox"/> Colostomy	<input type="checkbox"/> Muscle biopsy	<input type="checkbox"/> Prostate surgery
<input type="checkbox"/> Wrist arthroscopy	<input type="checkbox"/> Disk removal	<input type="checkbox"/> Broken bone fixation	
<input type="checkbox"/> Shoulder arthroscopy	<input type="checkbox"/> Gastric bypass	<input type="checkbox"/> Pacemaker	

**Other past surgical history:** \_\_\_\_\_

**Review of Systems (please check all appropriate boxes)**

**Constitutional:**  fever  fatigue  night sweats  unintentional weight loss

**HEENT:**  vision changes  headaches  hearing loss

**Respiratory:**  cough  wheezing  shortness of breath

**Cardiovascular:**  chest pain  irregular heart beat

**Gastrointestinal:**  vomiting  diarrhea  constipation  abdominal pain

**Genitourinary:**  pain with urination  blood in the urine

**Metabolic/Endocrine:**  frequent urination  frequent thirst or hunger  cold or heat intolerance

**Neurologic/Psychiatric:**  dizziness  emotional disturbances

**Musculoskeletal:**  bone/joint pain  bone/joint swelling  weakness

**Hematologic:**  bruising  bleeding

**Immunologic:**  food allergies  seasonal allergies  environmental allergies

**Social History**

**Hand dominance:**  Left  Right    **Exercise level:**  Sedentary  Moderate  Vigorous

**Exercise frequency:**  Daily  3-5 times per week  1-2 times per week  occasionally  never

**Do you smoke?**  Yes  No    **If yes, how many packs per day?** \_\_\_\_\_    **For how many years?** \_\_\_\_\_

**How many drinks of alcohol do you consume in a typical week?** \_\_\_\_\_

## New Patient History Form (page 3 of 3)

### Family History

If one of your family members had or has any of the conditions listed below, please mark the appropriate boxes

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> ADD/ADHD                | <input type="checkbox"/> Colitis             | <input type="checkbox"/> Gout                | <input type="checkbox"/> Arthritis           |
| <input type="checkbox"/> Alcoholism/Cirrhosis    | <input type="checkbox"/> Heart failure       | <input type="checkbox"/> Hearing loss        | <input type="checkbox"/> Osteoporosis        |
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Heart defects       | <input type="checkbox"/> Hodgkin's disease   | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Alzheimer's             | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Vascular disease    |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> Seizure disorder    |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Depression          | <input type="checkbox"/> Liver disease       | <input type="checkbox"/> Thyroid disease     |
| <input type="checkbox"/> Blood/Bleeding problems | <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Mental illness      | <input type="checkbox"/> Anesthesia problems |
| <input type="checkbox"/> Bone cancer             | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Osteoporosis        |
| <input type="checkbox"/> Heart disease           | <input type="checkbox"/> Drug abuse          | <input type="checkbox"/> Muscle disease      |  |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Mental delay        | <input type="checkbox"/> Obesity             |  |

### Your Current Problem

How long have you been having this problem? \_\_\_\_\_

How frequently does it occur?  Persistently  Intermittently  Occasionally  Rarely

How long does it last when it occurs?  Less than 5 minutes  5-15 minutes  15-30 minutes  30-60 minutes  
 Greater than 60 minutes  Problem is always there

On a scale of 1 to 10, how severe is it? \_\_\_\_\_ Does the pain travel?  Yes  No

Where is the problem (please include which side of your body if applicable)? \_\_\_\_\_

How would you describe the pain?  Aching  Burning  Dull  Piercing  Sharp  Throbbing

Is your problem the result of any injury?  Yes  No If yes, what was the date of the injury? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If your problem is the results of any injury, how did the injury occur? \_\_\_\_\_

Is your problem made worse by any of the following?  Bending  Climbing stairs  Descending stairs  Lifting  
 Movement  Pushing  Sitting  Prolonged standing  Walking Other \_\_\_\_\_

Is your problem made better by any of the following?  Brace/splint  Elevation  Exercise  Heat  Ice  
 An injection  Massage  Prescription meds  Over the counter meds  Movement/Walking  Physical therapy  
 Rest  Stretching Other \_\_\_\_\_

Check all appropriate boxes if you are experiencing any of these symptoms as a result of your problem:

- |   |   |                                   |   |
|---|---|-----------------------------------|---|
| <input type="checkbox"/> Bruising                   | <input type="checkbox"/> Instability          | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling in the arms |
| <input type="checkbox"/> Crunching noises           | <input type="checkbox"/> Limping              | <input type="checkbox"/> Popping  | <input type="checkbox"/> Tingling in the legs |
| <input type="checkbox"/> Decreased motion           | <input type="checkbox"/> Locking              | <input type="checkbox"/> Spasms   | <input type="checkbox"/> Tenderness           |
| <input type="checkbox"/> Difficultly falling asleep | <input type="checkbox"/> Night time awakening | <input type="checkbox"/> Swelling | <input type="checkbox"/> Weakness             |