Date ___ / ___ / ____

Patient History Form

Name: _____ Date of Birth: _____ Sex: ☐Male ☐Female

Did your doctor refer you here? ☐No ☐Yes If yes, referring Physician: _____

Is this a work-related injury? ☐No ☐Yes If yes, name of employer: _____

Hand Dominance: ☐Right ☐Left ☐Ambidextrous Occupation: _____

Current Medications:

_____

_____

_____

Medication Allergies (please also list reaction if known):

_____

_____

Do you smoke cigarettes? ☐No ☐Yes How many packs per day?_____ For how many years?_____
Non-Cigarette Tobacco use:_____
Do you consume alcoholic beverages? ☐No ☐Yes
On average, how many alcoholic beverages do you consume per week?_____

Cardiovascular History:

Medical Conditions:
☐High Blood Pressure
☐High Cholesterol
☐A Fib (irregular heart rate)
☐Deep Vein Thrombosis (blood clot)
☐Coronary Artery Disease
☐Heart Attack
☐Heart Failure
☐Stroke
☐Heart Valve Disease
☐Vascular Disease
☐Other cardiac conditions or surgeries:

_____

_____

Surgeries:
☐Heart Bypass
☐Heart Stents
☐Pacemaker

Do you take blood thinners? ☐No ☐Yes
Do you have a cardiologist? ☐No ☐Yes
Cardiologist's Name: _____
☐ None apply

Pulmonary History:
Medical conditions:
☐Sleep Apnea
☐COPD
☐Asthma
☐Pulmonary Embolus (blood clot in lungs)
☐Other pulmonary history:_____

_____

☐ None apply

Rheumatologic History:
☐Gout
☐Rheumatoid Arthritis
☐Psoriatic Arthritis
☐Lupus
☐Fibromyalgia
☐Lyme Disease
☐Other rheumatologic history: _____

_____

☐None apply

Date ___ / ___ / _____

Name: _____ Date of Birth: _____

Other Medical History:
☐Anxiety
☐Depression
☐Esophageal reflux/GERD
☐Stomach Ulcers
☐Kidney Disease
☐Liver disease
☐Osteoporosis
☐Enlarged prostate
☐Substance use disorder
☐Hepatitis
☐HIV/AIDS
☐Cancer (type)_____
☐Other: _____
_____
☐None Apply

Endocrine History:
☐Diabetes
☐Hypothyroidism
☐Hyperthyroidism
☐Other endocrine history: _____
_____
☐ None Apply

Family Medical History (Parents or Siblings):
☐Connective Tissue Disorder: _____
☐Clotting Disorder: _____
☐Autoimmune Disease: _____
☐ None Apply

Past **Orthopedic** Surgeries (Please include dates and surgeon if known):
_____
_____
_____
_____
_____

Past **Non-Orthopedic** Surgeries (Please include dates if known):
_____
_____
_____
_____
_____

Please return to the desk once completed in order to be checked in for your appointment.