**PATIENT HEALTH HISTORY**

NAME:_____GENDER:_____DOB:_____AGE:_____WEIGHT:_____HEIGHT:_____

OCCUPATION:_____PHARMACY:_____

PRIMARY CARE PROVIDER:_____LOCATION:_____

REFERRING PROVIDER:_____LOCATION:_____

Is this the result of a: ☐ Injury ☐ Car Accident ☐ Workplace Injury ☐ Not an Injury

Date of Onset:_____ Date of Injury:_____

**REASON FOR TODAY'S VISIT**:_____ ☐ R ☐ L

What makes it feel worse?:_____

What makes it feel better?:_____

What is it keeping you from being able to do?:_____

Describe your pain: ☐ achy ☐ sharp ☐ burning ☐ other _____

Current pain level: (1-10, 10 being the worst)_____ Pain at its worst:_____

Have you consulted other health care providers (ie: doctors, physical therapists, chiropractors, etc) for this problem? (please list below) ☐ Yes ☐ No

Provider:_____ Treatment:_____ Approximate Date:_____

**PAST MEDICAL HISTORY Do you have, have you had, do you take medications for?**

| | | | | | |
|---|---|---|---|---|---|
| Anxiety | ☐ Y ☐ N | Heart Attack | ☐ Y ☐ N | Psoriasis | ☐ Y ☐ N |
| Asthma | ☐ Y ☐ N | High Cholesterol | ☐ Y ☐ N | Rheumatoid Arthritis | ☐ Y ☐ N |
| Diabetes | ☐ Y ☐ N | Hypertension | ☐ Y ☐ N | Seizures | ☐ Y ☐ N |
| Blood Clots/DVT/PE | ☐ Y ☐ N | Kidney Disease | ☐ Y ☐ N | Sleep Apnea | ☐ Y ☐ N |
| Bowel Disease | ☐ Y ☐ N | Liver Disease | ☐ Y ☐ N | Stroke | ☐ Y ☐ N |
| Cancer-Type: | ☐ Y ☐ N | MRSA Infection | ☐ Y ☐ N | Thyroid Disease | ☐ Y ☐ N |
| Depression | ☐ Y ☐ N | Osteoporosis | ☐ Y ☐ N | Tuberculosis (TB) | ☐ Y ☐ N |
| Gout | ☐ Y ☐ N | Pregnant (currently) | ☐ Y ☐ N | Ulcers | ☐ Y ☐ N |

**PAST SURGICAL HISTORY** **History of Anesthesia problems?** ☐ Yes ☐ No

| Procedure | Date | Surgeon |
|---|---|---|
| | | |
| | | |
| | | |

**MEDICATION LIST** (Include prescriptions, herbals and over the counter medications)

| Medication | Strength (dosage) | Times per Day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Allergies** ☐Yes (See Below)☐ No Known Drug Allergies

| Medication You are Allergic To | Reaction |
|---|---|
| | |
| | |
| | |

**Family History** Do any immediate family members have or have had?

| | | | | | |
|---|---|---|---|---|---|
| Anesthesia Problems | ☐ Y ☐ N | Diabetes | ☐ Y ☐ N | Osteoarthritis | ☐ Y ☐ N |
| Blood Clots/PE | ☐ Y ☐ N | Heart Attack | ☐ Y ☐ N | Osteoporosis | ☐ Y ☐ N |
| Cancer- Type: | ☐ Y ☐ N | MRSA Infection | ☐ Y ☐ N | Rheumatoid Arthritis | ☐ Y ☐ N |

**SOCIAL HISTORY**

Do you drink alcohol? ☐ Y☐ N If yes, how many drinks per day?_____

Do you use tobacco? ☐ Y ☐N What type?_____How much?_____For how many years?_____

Sports, hobbies, or interests?_____

What is your living situation?☐ Alone ☐ Spouse/Family ☐ Friends ☐ Nursing home/Assisted living

**REVIEW OF SYSTEMS Do you have? (Answer yes or no for each)**

| | | | | | |
|---|---|---|---|---|---|
| Fevers, chills | ☐ Y ☐ N | Cough | ☐ Y ☐ N | Balance issues | ☐ Y ☐ N |
| Night sweats | ☐ Y ☐ N | Nausea | ☐ Y ☐ N | Leg numbness/tingling | ☐ Y ☐ N |
| Weight loss | ☐ Y ☐ N | Vomiting | ☐ Y ☐ N | Arm numbness/tingling | ☐ Y ☐ N |
| Headaches | ☐ Y ☐ N | Abdominal pain | ☐ Y ☐ N | Excessive thirst | ☐ Y ☐ N |
| Dizziness | ☐ Y ☐ N | Heartburn/Reflux | ☐ Y ☐ N | Anxiety | ☐ Y ☐ N |
| Chest pain | ☐ Y ☐ N | Urinary changes | ☐ Y ☐ N | Depression | ☐ Y ☐ N |
| Shortness of breath | ☐ Y ☐ N | Rash | ☐ Y ☐ N | Excessive bruising | ☐ Y ☐ N |

☐ I have none of the above symptoms.

☐ My primary care physician is aware of my symptoms. **(Please note that if your Primary Care Provider is not aware of the above symptoms, you should notify him/her.)**

**Patient Signature:_____Guardian (if under 18):_____Date:_____**