



PATIENT HISTORY FORM

Date: \_\_\_\_\_
Name: \_\_\_\_\_
Address: \_\_\_\_\_ Sex: M / F
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Home #: \_\_\_\_\_ Alternate#: \_\_\_\_\_
Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_
Social Security #: \_\_\_\_\_
Referring Physician: \_\_\_\_\_
Primary Care Physician: \_\_\_\_\_
Emergency Contact: \_\_\_\_\_
Phone #: \_\_\_\_\_

What is the reason for your visit? \_\_\_\_\_

What is your occupation/profession? \_\_\_\_\_ Are you right or left handed? \_\_\_\_\_

Did you have an Injury? Yes No If yes, When? \_\_\_\_\_ Where? \_\_\_\_\_

Describe your injury: \_\_\_\_\_

If you did not have an injury, how long have you had symptoms? \_\_\_\_\_

What treatment(s) have you had for this problem, and has it helped? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HISTORY OF PRESENT ILLNESS Physician will fill out. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PAST MEDICAL HISTORY Please check and/or list your medical problems:

- \_\_\_ High Blood Pressure \_\_\_ Ulcers \_\_\_ Other: \_\_\_\_\_
\_\_\_ Diabetes \_\_\_ Kidney disease \_\_\_\_\_
\_\_\_ Heart disease \_\_\_ Stroke \_\_\_\_\_
\_\_\_ Cancer \_\_\_ Osteoporosis \_\_\_\_\_
\_\_\_ Blood clots/DVT \_\_\_ Irregular heart beat \_\_\_\_\_

PAST SURGICAL HISTORY Please check and/or list your previous surgeries:

- \_\_\_ Hip replacement \_\_\_ Appendix \_\_\_ Other: \_\_\_\_\_
\_\_\_ Knee replacement \_\_\_ Gallbladder \_\_\_\_\_
\_\_\_ Arthroscopy \_\_\_ Prostate \_\_\_\_\_
\_\_\_ Shoulder/rotator cuff \_\_\_ Pacemaker \_\_\_\_\_
\_\_\_ Fracture surgery \_\_\_ Hysterectomy \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

**MEDICATIONS** List your present medications and supplements (**with doses and frequency**):

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

**ALLERGIES** Are you allergic to any medications? Yes \_\_\_ No \_\_\_ (If yes, please list and describe what happens)  
 Are you allergic to any metals? Yes \_\_\_ No \_\_\_ (If yes, please list and describe what happens)

---



---



---

**OTHER HISTORY**

Do you smoke? Yes\_\_\_ No\_\_\_ packs per day \_\_\_\_ Do you drink alcohol? Yes\_\_\_ No \_\_\_ drinks per day \_\_\_\_

**REVIEW OF SYSTEMS** Do you have any of the following problems? Circle yes or no.

<i>General</i>			<i>Psychological</i>		
Unexpected weight change	Yes	No	Do you feel depressed?	Yes	No
Chills	Yes	No	Do you feel anxious?	Yes	No
Fevers	Yes	No	Are you claustrophobic?	Yes	No
<i>Neurological</i>			<i>Musculoskeletal</i>		
Tremors	Yes	No	Bone pain	Yes	No
Dizzy spells	Yes	No	Joint pain	Yes	No
Numbness/tingling	Yes	No	Muscle pain	Yes	No
<i>Eyes</i>			<i>Endocrine</i>		
Double vision	Yes	No	Excessive thirst	Yes	No
Glaucoma	Yes	No	Tired/sluggish	Yes	No
<i>Ear/Nose/Throat</i>			<i>Hematologic</i>		
Hearing problems	Yes	No	Blood clotting problems	Yes	No
Sore throat	Yes	No	Excessive bleeding	Yes	No
Sinus infections	Yes	No	Easy bruising	Yes	No
<i>Cardiovascular</i>			<i>Vascular</i>		
Chest pain	Yes	No	Leg pain with walking	Yes	No
Palpatations	Yes	No	Leg pain at rest	Yes	No
			History of blood clots	Yes	No
<i>Pulmonary</i>			<i>Integumentary</i>		
Wheezing	Yes	No	Do you have a rash?	Yes	No
Frequent cough	Yes	No			
Shortness of breath	Yes	No			
<i>Gastrointestinal</i>			Have you had a bone density Scan to test for osteoporosis?		
Abdominal pain	Yes	No		Yes	No
Nausea/vomiting	Yes	No	If yes, how long ago?		
<i>Genitourinary</i>			How much do you weight? _____ lbs		
Difficulty urinating	Yes	No	How tall are you? _____ ft _____ inches		
Burning with urination	Yes	No			