New Patient Medical History Form

Date: _____ Patient Name:_____

Age _____ Sex: ☐M ☐F Height_____ Weight_____ Date of Birth _____

Referring Physician:

Name: _____

Specialty: _____

Address: _____

_____

Phone: _____

Primary Care Physician: ☐ Please check if same

Name: _____

Specialty: _____

Address: _____

_____

Phone: _____

Chief Complaint:

What is the reason for your visit: _____

Describe in detail the injury: _____

_____

Date of Injury or Pain: _____

Are you right or left handed (circle one) ? Right / Left

Were you injured? ☐ No ☐Automobile ☐ Work related ☐ Sports ☐ Home ☐ Other: _____

On a scale of 0-10 (10 is the worst) how severe is your pain? (Circle) 0 1 2 3 4 5 6 7 8 9 10

Quality of the pain is: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

The pain is: ☐ Constant ☐ Comes and goes (intermittent)

What makes your symptoms better? _____

What makes your symptoms worse? _____

What does this limit you from: _____

Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged

Treatment:

Please check previous types of treatment for this problem	**Have they helped?**	
☐ Anti-inflammatory medications (i.e. Advil, Motrin, Aleve)	☐ Yes	☐ No
☐ Narcotic medications (ie Vicodin, Percocet)	☐ Yes	☐ No
☐ Brace / Splint	☐ Yes	☐ No
☐ Physical therapy	☐ Yes	☐ No
☐ Cane / Crutch	☐ Yes	☐ No
☐ Injection (Type: _____)	☐ Yes	☐ No

Have you seen an orthopedic surgeon for this problem? (If yes please list below) ☐ Yes ☐ No

Surgeon: _____

Have you had surgery for this problem? (If yes please list below) ☐ Yes ☐ No

Procedure: _____ Surgeon: _____ Date: _____

Procedure: _____ Surgeon: _____ Date: _____

Previous Tests: Please check any of the tests that you have had done for this problem

☐ X-rays ☐ MRI ☐ CT ☐ Bone Scan ☐ Nerve Test (EMG/NCV)

Date: _____ Patient Name: _____

Past Medical History: Do you have currently or have you ever had any of the following?

Anemia:	☐ Yes	☐ No
Anesthesia Problems:	☐ Yes	☐ No
Angina:	☐ Yes	☐ No
Asthma:	☐ Yes	☐ No
Atrial Fibrillation:	☐ Yes	☐ No
Bladder Infection:	☐ Yes	☐ No
Blood Clots:	☐ Yes	☐ No
Bronchitis:	☐ Yes	☐ No
Cancer:	☐ Yes	☐ No
Cellulitis:	☐ Yes	☐ No
Congestive Heart Failure:	☐ Yes	☐ No
Coronary Artery Disease:	☐ Yes	☐ No
Depression:	☐ Yes	☐ No
Diabetes:	☐ Yes	☐ No
Dialysis:	☐ Yes	☐ No

Diverticulitis:	☐ Yes	☐ No
Elevated Cholesterol:	☐ Yes	☐ No
Emphysema/COPD:	☐ Yes	☐ No
Epilepsy:	☐ Yes	☐ No
Fractures:	☐ Yes	☐ No
Glaucoma:	☐ Yes	☐ No
Gout:	☐ Yes	☐ No
Heart Attack:	☐ Yes	☐ No
Heart Arrhythmia:	☐ Yes	☐ No
Hepatitis:	☐ Yes	☐ No
High Blood Pressure:	☐ Yes	☐ No
Hiatal Hernia:	☐ Yes	☐ No
HIV:	☐ Yes	☐ No
Kidney Disease:	☐ Yes	☐ No
Kidney Stones:	☐ Yes	☐ No

Leukemia:	☐ Yes	☐ No
Liver Disease:	☐ Yes	☐ No
Pancreatitis:	☐ Yes	☐ No
Pneumonia:	☐ Yes	☐ No
Reflux:	☐ Yes	☐ No
Rheumatoid Arthritis:	☐ Yes	☐ No
Sinus Problems:	☐ Yes	☐ No
Sleep Apnea:	☐ Yes	☐ No
Stomach Ulcers:	☐ Yes	☐ No
Stroke:	☐ Yes	☐ No
Thyroid Disorder:	☐ Yes	☐ No
TIA:	☐ Yes	☐ No
Osteoporosis:	☐ Yes	☐ No
Other: _____	☐ Yes	☐ No

Past Surgical History: [Please list all surgical procedures below]

Surgery:	Date preformed:	Surgery:	Date preformed:

Medications, Vitamins and Supplements: [Please attach list if necessary]

Name	Strength (mg)	Times/day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Date: _____ Patient Name: _____

Allergies:

Are you allergic to any metals or jewelry: ☐ Yes ☐ No If yes please list: _____
Are you allergic to Latex: ☐ Yes ☐ No
Are you allergic to any medications: ☐ Yes ☐ No If yes please list below and reaction:

_____
_____
_____
_____

Family History: Please state which relatives have any of the following:

☐ Diabetes: _____ ☐ Stroke: _____
☐ Heart Disease: _____ ☐ Cancer: _____
☐ Rheumatoid Arthritis: _____ ☐ Other: _____

Social History:

Occupation: _____
Employer: _____
Where do you live: ☐ Home ☐ Apartment ☐ Retirement Community
Who do you live with: _____
Do you use tobacco: ☐ Yes ☐ No If yes, how many per day? _____
Do you use alcohol: ☐ Yes ☐ No If yes: how many drinks per day?_____

Review of Systems: [Please check all that apply] Please explain below for any that apply:

Constitutional		
Fevers	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Weight Loss	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Musculoskeletal		
Diffuse Joint Pain	☐ Yes	☐ No
Focal Joint Pain	☐ Yes	☐ No
Muscle Pain	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No
Gastrointestinal		
Heartburn	☐ Yes	☐ No
Abdominal Pain	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No

Neurological		
Poor Balance	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Respiratory		
Wheezing	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Cardiovascular		
Chest Pain	☐ Yes	☐ No
Leg Swelling	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No
Poor Circulation	☐ Yes	☐ No
Genitourinary		
Difficult Urinating	☐ Yes	☐ No

Painful Urination	☐ Yes	☐ No
Frequency	☐ Yes	☐ No
Retention	☐ Yes	☐ No
Psychiatric		
Depression	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Eyes/Nose/Throat		
Poor Vision	☐ Yes	☐ No
Hearing Loss	☐ Yes	☐ No
Dif Swallowing	☐ Yes	☐ No
Integument		
Rashes	☐ Yes	☐ No
Blisters	☐ Yes	☐ No
Open Sores	☐ Yes	☐ No

_____
_____
_____

Please Sign: The information in this form is accurate, to the best of my knowledge.

Patient Signature: _____ Date: _____

For Office Use Only BMI: _____
Physician Signature: _____ Date: _____