

PATIENT HISTORY FORM

NOTE: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released without your authorization to do so.

TODAY'S DATE ____/____/____

FAMILY DOCTOR _____

NAME _____ DATE of BIRTH ____/____/____ Social Security # _____

Were you referred to us by another healthcare professional? (If yes, please state name) _____

CHIEF COMPLAINT--What is the main reason for your visit today? (Please describe your problem in detail):

History of Present Illness/Condition

Location of the problem: Left Right
knee shoulder ankle/foot hip elbow wrist
other: _____

Date symptoms began: _____

Symptoms: (please circle those that apply to this condition)

Constant or Intermittent	Stiffness
Feels stable or unstable	Gives way/buckles
Catching sensations	Loss of Strength
Hurts to bear weight	Numbness/tingling

Please rate your pain: 0=no pain 10=severe pain
0 1 2 3 4 5 6 7 8 9 10

Occupation: _____

Is this condition work-related? Yes No

Review of Systems

Do you now or have you had ANY problems?

Circle YES or NO

Chest pain	Y	N	
Shortness of breath	Y	N	
Fever or Chills	Y	N	
Sinus Problems	Y	N	
Sore throat	Y	N	
Bloody cough	Y	N	
Indigestion or heartburn	Y	N	
Dark, tarry stools	Y	N	
Bloody stools	Y	N	
Bloody urine	Y	N	
Kidney problems	Y	N	
Urinary tract infection	Y	N	
Blood clotting problem	Y	N	
Back pain	Y	N	
Neck pain	Y	N	
Are you pregnant?	Y	N	Not sure

Past Medical & Social History

List all chronic illnesses/conditions:

(Ex: diabetes, heart disease, high blood pressure, etc)

List any past surgeries **and** dates:

Do you smoke? Y N

If yes, how much? _____

Do you drink alcohol? (Circle one)

Never Occasional Regularly Frequent

Are you taking any medications and/or supplements? Y N

If yes, please list all, including any non-prescription medications.

Do you have medication allergies? Y N

If yes, please list _____

Office use only

Height _____ Weight _____ Temp _____