

**Patient History**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Age: \_\_\_\_\_

Sex: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Hx Present Illness: \_\_\_\_\_

Onset/Injury Date: _____	<b>Medications</b>
Mechanism of Injury: _____	
Location: _____	
Severity: Minor, Moderate, Severe	
Modifying Factors: Rest, Heat, Cold, Limb Elevation	
Context: Improving, Worsening, Recurring	
Quality: Sharp, Dull, Throbbing, Burning, Aching	
Duration: Intermittent, Constant, Minutes	
Timing: With Exercise, Nightly, Morning, After Meals	
Associated Signs & Symptoms: Bruising, Numbness, Tingling	
Treatment Rec'd for this Problem: _____	

**PAST MEDICAL HISTORY**

Illnesses: Diabetes-Insulin/Non-Insulin, Heart Disease, High Blood Pressure, Blood Clot, Ulcers, Hiatal Hernia:

Operations: \_\_\_\_\_

Injuries: \_\_\_\_\_

Allergies: \_\_\_\_\_

**FAMILY MEDICAL HISTORY Has Any Relative ever Had the Following? (Please Circle)**

Heart Problems	Father	Mother	Sister	Brother	Other
High Blood Pressure	Father	Mother	Sister	Brother	Other
Arthritis	Father	Mother	Sister	Brother	Other
Diabetes	Father	Mother	Sister	Brother	Other
Stroke	Father	Mother	Sister	Brother	Other
Cancer	Father	Mother	Sister	Brother	Other
Osteoporosis	Father	Mother	Sister	Brother	Other
Blood Clots	Father	Mother	Sister	Brother	Other

**SOCIAL HISTORY**

Right or Left handed? \_\_\_\_\_ Do you: Exercise Regularly Y N Use Seatbelts Regularly Y N

Marital Status? \_\_\_\_\_ Use Drugs? Y N Use Alcohol? Y N

Occupation? \_\_\_\_\_ Smoke? Y N \_\_\_\_\_ Packs/day for \_\_\_\_\_ years

Patient History

**REVIEW OF SYSTEMS**

**ALL SYSTEMS ARE REVIEWED AND NEGATIVE EXCEPT AS CIRCLED.**

- 1. **Constitution:** Weight Gain, Weight Loss, Chills, Fevers, Night Sweats
- 2. **Eyes:** Visual Loss, Blurry Vision, Double Vision, Eye Pain, Glaucoma
- 3. **Ears, Nose, Mouth, Throat:** Hearing Loss, Ringing in Ears, Dizziness, Nosebleeds, Hoarseness, Sinus Infections, Difficulty Swallowing, Dentures
- 4. **Cardiovascular:** Chest Pain, Irregular Heartbeat, Shortness of Breath, Edema, Cold Feet, Heart Murmur, Claudication, Hypertension, History of Rheumatic Fever
- 5. **Respiratory:** Coughing, Shortness of Breath, Wheezing, Coughing up Blood, Emphyzema, Asthma
- 6. **Gastrointestinal:** Appetite Change, Nausea and Vomiting, Abdominal Pain, Diarrhea, Constipation, Ulcers, Hemorrhoids, Hernia, Blood in Stool, Hepatitis, Cirrhosis
- 7. **Genitourinary:** Burning on Urination, Frequency of urination, Blood in Urine, Pain on Urination, Kidney Stones, History of Infection, Menstrual Problems, Prostate Problems
- 8. **Musculoskeletal:** Fractures, Muscle Pain, Stiffness in Joints, Weakness, Atrophy, History of Arthritis
- 9. **Integumentary:** Rashes, Itching, Bruising, Lesions, Ulcers, Hair Loss, Moles, Nail Changes Brittle/Coarse
- 10. **Neurological:** Weakness, Atrophy, Tremors, Seizures, Pain, Numbness, Incontinence, Speech Problems, Changes in Smell, Hearing, Taste, Temperature Sensitivity
- 11. **Psychiatric:** Mood Swings, Anxiety, Depression, Fears, Sleep Disturbances
- 12. **Endocrine:** Weight loss/gain, Hair Loss/Increase, Temperature Sensitivity, Excessive Thirst
- 13. **Hematologic/Lymphatic:** Bleeding, Bruising, Blood Clots, History of Anemia, Enlarged Lymph Nodes, Abnormal Fatigue
- 14. **Allergic/Immunologic:** Allergies, Hayfever, Drug Allergies, Dermatitis Sensitivity, Frequent Infections, Anaphylaxis

**TO BE COMPLETED BY PHYSICIAN**

**Other Pertinent Information:**


**TO BE COMPLETED BY PHYSICIAN**

<b>Working Diagnoses: Primary : Pending</b>		<hr/>
<b>Secondary</b>	1)	<hr/>
	2)	<hr/>
	3)	<hr/>
	4)	<hr/>
	5)	<hr/>