PATIENT HISTORY FORM

NAME: ____ **DOB:** ____________________

YOUR INJURY/WHAT HURTS: ____

DATE OF INJURY/HOW LONG HAS IT HURT: ____

RIGHT HANDED OR LEFT HANDED (PLEASE CIRCLE ONE): RIGHT LEFT

HEIGHT: ___________________ **WEIGHT:** ____________________

SMOKING HISTORY: YES OR NO PPD: ____________ **ALOCHOL:** YES OR NO ________DRINKS PER DAY

MEDICATION (PLEASE LIST DOSE):

____ ____

____ ____

____ ____

PAST MEDICAL HISTORY:

HEART ATTACK/MI THYROID/HYPOTHYROID ASTHMA DIABETES CANCER (TYPE): ___________________

HYPERTENSION/HTN KIDNEY/RENAL DISEASE ARTHRITIS SEIZURES REFLUX/ULCERS

TUBERCULOSIS/TB LUNG DISEASE/COPD EMPHYSEMA GOUT HEART FAILURE

DVT/BLOOD CLOTS HEPATITIS/LIVER SLEEP APNEA HIV OTHER: _____________________________

PAST SURGERIES: ____

ALLERGIES TO MEDICATIONS: ____

REVIEW OF SYSTEMS (PLEASE CIRCLE IF ANY APPLY):

GENERAL: NONE FEVER/CHILLS FATIGUE WEIGHT LOSS/GAIN INTENTIONAL WEIGHT LOSS DIZZINESS HEADACHES LOSS OF CONSCIOUSNESS

NEUROLOGIC: NONE LOSS OF BALANCE WEAKNESS CLUMSINESS NUMBNESS/TINGLING TREMORS

CARDIAC: NONE CHEST PAIN PALPITATION FAINTING MURMURS

PULMONARY: NONE SHORTNESS OF BREATH COUGH WHEEZING SNORING

GASTROENTESTINAL: NONE NAUSEA/VOMITING ABDOMINAL PAIN DIARRHEA BLOODY/TARRY STOOL

GENITOURINARY: NONE PAINFUL/DIFFICULT/FREQUENT/BLOODY URINATION FLANK PAIN KIDNEY STONES

HEMOTOLOGY: NONE EXCESSIVE BRUISING EASY/EXCESSIVE/PROLONGED BLEEDING

SKIN: NONE RASH ITCHING REDNESS SKIN CHANGES MASSES/BUMPS

PYSCIATRIC: NONE ANXIETY DEPRESSION NERVOUSNESS

EYES: NONE BLURRY/DOUBLE/CLOUDY VISION EYE PAIN CONTACT LENSES/GLASSES

ENT: NONE HEARING LOSS RINGING IN EARS EAR PAIN SORE THROAT DIFFICULTY SWALLOWING

ENDOCRINE: NONE EXCESSIVE THIRST/URINATION HEAT/COLD INTOLERANCE

SIGNATURE: ____ **DATE:** ___________________