Patient History

Name:_____ **Date**_____

Occupation: _____ Age: _____ Sex: _____

Reason for Today's Visit:

- Date of Onset: _____ Symptoms: _____
- Are you here due to an injury? ☐ No ☐ Yes
- Cause of the injury (example: fell on ice)? _____
- What were you doing at the time of the injury (example: ice skating)? _____
- Where did the injury occur (example: Big Dipper ice rink)? _____
- When injured were you engaged in
  _____ Work? If yes, have you filed a workers comp claim?_____
  _____ Military activity?
  _____ Volunteer activity?
  _____ Other Activity? (please specify)_____

Have you sought prior medical attention for this problem? ☐ **No** ☐ **Yes**

If YES, from whom?_____ Date_____

Were x-rays taken: ☐ No ☐ Yes If yes, what part of body?_____

List current medications/herbals or check ☐ **None:**_____

List all Allergies or check ☐ **None:**_____

Medical History: (check all that apply)

Illnesses

☐ Diabetes ☐ Heart Trouble ☐ Hypertension ☐ Emphysema ☐ Asthma ☐ TB
☐ Ulcer ☐ Cancer ☐ Thyroid ☐ Hepatitis ☐ Other (explain)

Operations

☐ Tonsillectomy ☐ Appendectomy ☐ Hernia Repair ☐ Hysterectomy ☐ D&C ☐ Gallbladder
☐ Hemorrhoidectomy ☐ Knee ☐ Shoulder ☐ Ankle ☐ Other (Explain)

Transfusions: ☐ No ☐ Yes _____

Hospitalizations other than surgery: ☐ No ☐ Yes _____

Family History:

	Age	Living/Deceased	Illnesses/Cause of Death
Mother			
Father			
Brothers			
Sisters			
Children			

Habits:
Smoke Cigarettes: ☐ No ☐ Yes Drink Alcohol: ☐ No ☐ Yes Use Drugs: ☐ No ☐ Yes

Patient History

Name:_____ **Date**_____

Review of Systems: (Please check all of your present or recent conditions)

General
- _____ Weight loss
- _____ Weight gain
- _____ Poor appetite
- _____ Chills
- _____ Fevers
- _____ Night sweats

Skin
- _____ Rash
- _____ Hives
- _____ Lesions

HEENT
- _____ Hay Fever
- _____ Postnasal discharge
- _____ Hoarseness
- _____ Visual Problems
- _____ Hearing loss

Cardiovascular
- _____ Chest pain (angina)
- _____ Palpitations (rapid heartbeat)
- _____ Irregular heartbeat (arrhythmia)
- _____ Rheumatic fever
- _____ Swollen ankles (pedal edema)
- _____ Shortness of breath on exertion
- _____ Shortness of Breath at night

Pulmonary
- _____ Shortness of breath
- _____ Wheezing
- _____ Coughing
- _____ Coughing up blood (hematemesis)

Genitourinary
- _____ Frequent urination
- _____ Urgent urination
- _____ Painful urination
- _____ Need to awaken to urinate
- _____ Blood in urine
- _____ Penile or Vaginal discharge
- _____ Kidney stone pain

Gastrointestinal
- _____ Indigestion
- _____ Gas
- _____ Nausea
- _____ Vomiting
- _____ Vomiting Blood
- _____ Yellow Skin
- _____ Abdominal pain
- _____ Constipation
- _____ Diarrhea
- _____ Black stools
- _____ Rectal bleeding

Psychiatric
- _____ Anxiety
- _____ Depression
- _____ Other_____

Lymphatic
- _____ Lymph node swelling
- _____ Note tenderness

Endocrine
- _____ Excessive urination
- _____ Excessive thirst
- _____ Excessive appetite
- _____ Heat intolerance
- _____ Cold intolerance

Neurological
- _____ Loss of consciousness
- _____ Headaches
- _____ Dizziness
- _____ Seizures (fits)
- _____ Fainting Spells

Females:

Are you pregnant? ☐No ☐ Yes

Date of Last menstrual cycle _____

Height:_____ Weight:_____ Dominance: Right Hand_____(or) Left Hand_____

Signature:_____ Date:_____

I certify that the information provide above is correct and true.

Notes:

Provider Reviewed:
Initials:_____ Date:_____
Initials:_____ Date:_____
Initials:_____ Date:_____
Initials:_____ Date:_____
Initials:_____ Date:_____