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 to anyone without your authorization to do so.

TODAY'S DATE ____/____/____ FAMILY DOCTOR _____

NAME_____ DATE OF BIRTH ____ /____ /____ Social Security #_____

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

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

_____

_____

History of Present Illness

Location of the problem: Left Right (circle one)

Knee Shoulder Ankle Hip

Other: _____

Symptoms are: Mild Moderate Severe (Circle one)

Date Symptoms began: _____

Symptoms are/include: (circle all that apply)

Constant Intermittent Sharp Dull

Feels stable Feels unstable Gives way/buckles

Catching sensations Hurts to bear weight

Numbness/ Tingling Dead arm sensations

Loss of strength Stiffness

Review of Systems

Do you now or have you had any problems?

Circle **Y**es or **N**o

Chest pain	Y	N
Indigestion / heartburn	Y	N
Fever or Chills	Y	N
Sinus problems	Y	N
Shortness of breath	Y	N
Bloody cough or stools	Y	N
Sore throat	Y	N
Dark, tarry 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

Office use only
Height _____ Weight _____ Temp_____

Occupation: _____

Is this condition work related? Y N

Past Medical & Social History

List all chronic illnesses/ condition.
(Example: diabetes, heart disease, high blood pressure, etc.)

_____

_____

_____

Are you on any medications? Y N (If yes, list all)

_____ _____

_____ _____

_____ _____

List any past surgeries

Surgery Date

_____

_____

_____

Do you have medication allergies? Y N (If yes, please list)

_____

_____

_____

Do you smoke? Y N
If yes, how much? _____

Do you drink alcohol? Y N
If yes, how much? _____