Patient History

It is the patient's responsibility to provide complete, accurate information when completing this form. Signature is required.

Patient Name (First, Last, MI)_____

Date of Birth (mm/dd/yyyy)_____ Are you here due to a work related injury? Y ___ N ____

Family Doctor Name:_____ Date of Last Visit (mm/dd/yyyy) ___/___/____

Please describe the reason for your visit today:_____

_____

CURRENT MEDICATIONS List all medications you are currently taking_____

_____

_____

ALLERGIES List all allergies, if no allergies write NONE_____

_____

SOCIAL HISTORY

Smoker? Yes___ How Much? _____ No___ Quit___ When? _____

Drink Alcohol? Yes ___ How Much? _____ No ____ Drug Abuse? Yes ___ No ___

PAST and FAMILY HISTORY Please indicate if you or a family member (indicate **M**other, **F**ather, **S**ister, **B**rother) have had any of the following.

Self	Family (list M,F,S,B)		Self	Family (list M,F,S,B)		Self	Family (list M,F,S,B)	
___	_____	Heart Attack/Angina	___	_____	Lupus	___	_____	Gout
___	_____	Heart Disease/Murmur/Failure	___	_____	Cancer	___	_____	Osteoarthritis
___	_____	High Blood Pressure	___	_____	Emphysema	___	_____	HIV
___	_____	Bleeding Tendencies	___	_____	Tuberculosis	___	_____	Migraines
___	_____	Glaucoma/Eye disease	___	_____	Phlebitis (blood clot)	___	_____	Diabete
___	_____	Prostate Problems	___	_____	Liver Disease	___	_____	Depression
___	_____	Ankylosing Spondylitis	___	_____	Gall Stones	___	_____	Stroke
___	_____	Osteoporosis	___	_____	Arthritis (unsp.)	___	_____	Kidney
___	_____	Hepatitis if yes, type____	___	_____	Rheumatoid Arthritis	___	_____	Pneumonia
___	_____	Seizure/Convulsions	___	_____	Asthma/Hay Fever		_____	Other

SURGICAL HISTORY Check if you have had any of the following surgeries.

___ Hip Replacement	___ Neck	___Tonsils/Adenoids	___ Ulcer (Stomach)
___ Knee Replacement	___ Back	___ Breast	___ Gallbladder
___ Arthroscopy	___ Appendectomy	___ Carpal Tunnel	___ Foot/Bunion
___ Torn Cartilage	___ Hysterectomy/D&C/Tubal	___ Eye/Cataract	_____
___ Hand	___ Hernia	___ Cystoscopy	_____ Other

REVIEW of SYSTEMS Circle **Y**es or **N**o if you have a problem with any of the following systems:

Constitutional (General Health)	Y	N	Skin	Y	N	Endocrine	Y	N
Ears/Nose/Throat	Y	N	Psychiatric	Y	N	Neurological	Y	N
Cardiovascular	Y	N	Gastrointestinal	Y	N	Respiratory	Y	N
Blood Disorder	Y	N	Eyes	Y	N	Urinary/Genital	Y	N
Allergy/Immunological	Y	N	Musculoskeletal	Y	N			

DO NOT COMPLETE THIS SECTION (OFFICE USE) Chief Complaint: _____

_____

Other Doctor Seen For this Problem:_____ Date last seen for problem:____/___/____

Accident? YES____ NO_____ If yes, DOI/Onset Date ___/___/_____ Accident Location_____

Height:_____ Weight:_____ Respiration:_____

Patient Signature:_____ **Date:** ___/___/____

Physician Signature:_____ **Date:**___/___/____ **MRN** _____