

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 Mother, Father, Sister, Brother) 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 Yes or No 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** _____