

Chart#: \_\_\_\_\_

# Medical History Form

(Please use black ink)

Patient Name: \_\_\_\_\_ Appointment Date: \_\_\_\_\_ with Dr. \_\_\_\_\_

Age: \_\_\_\_\_ Sex:  F  M Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Dominant hand:  R  L Did you bring X-rays?  Y  N

Who is your primary physician? (name): \_\_\_\_\_  MD  PA Clinic Name? \_\_\_\_\_

What is the reason for this visit?  Pain  Numbness  Weakness  Swelling  Stiffness  Other \_\_\_\_\_

Latex Allergy?  Y  N

What body part is involved? (Please mark the table below)

Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Wrist <input type="checkbox"/> R <input type="checkbox"/> L	Hand <input type="checkbox"/> R <input type="checkbox"/> L	Hip <input type="checkbox"/> R <input type="checkbox"/> L	Knee <input type="checkbox"/> R <input type="checkbox"/> L	Ankle <input type="checkbox"/> R <input type="checkbox"/> L	Foot <input type="checkbox"/> R <input type="checkbox"/> L	Neck <input type="checkbox"/>	Back <input type="checkbox"/>
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How long ago did it start? \_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years.

Have you had a problem like this before?  Y  N

In this section, check the **ONE** BOX which best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

- NO INJURY** (or onset was:  Gradual or  Sudden)  
Please indicate why do you think it started?
- INJURY** ( Accident  Sport (NOT Auto or Work)  
Date: \_\_\_\_\_ Please specify where and how it happened.  
What Sport? \_\_\_\_\_ School? \_\_\_\_\_
- INJURY AT WORK** Date: \_\_\_\_\_  
From a:  lift  twist  fall  bend  pull  reach
- WORK RELATED (BUT NO INJURY)**  
Date: \_\_\_\_\_ How did your job cause the problem?
- AUTO ACCIDENT** Date: \_\_\_\_\_ How was your car hit?

COMMENTS:

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On a scale of 0 – 10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain?  Sharp  Dull  Stabbing  Throbbing  Aching  Burning

The pain is:  Constant  Comes and goes (intermittent).

Does your pain wake you from your sleep?  Y  N

Do you have:  Swelling  Bruises  Numbness  Tingling  Weakness  
 Loss of control of bowel or bladder  Locking/Catching  Giving way

Since my problem started, it is:  Getting better  Getting worse  Unchanged

What makes your symptoms worse?  Standing  Walking  Lifting  Exercise  Twisting  Lying in bed  
 Bending  Squatting  Kneeling  Stairs  Sitting  Coughing  Sneezing

Which make your symptoms better?  Rest  Elevation  Ice  Heat  Other: \_\_\_\_\_

What medications are you taking now? \_\_\_\_\_

ALLERGIC TO ANY MEDICATIONS?  Y  N if yes please list and describe reaction: \_\_\_\_\_

Have you had any of these treatments? Injection:  Y  N Brace:  Y  N Physical Therapy:  Y  N Cane/Crutch:  Y  N

Were you seen in the E.R. for this problem?  N  Y Which E.R.? \_\_\_\_\_ Date: \_\_\_\_\_

Are you here today as a result of an E.R. Visit?  N  Y Who saw you in E.R.? \_\_\_\_\_  MD  PA

What test/scans have you had for this problem?

X-Rays  MRI  CAT Scan  Bone Scan  Nerve Test (EMG/NCV) Where? \_\_\_\_\_

Have you already had surgery for a problem in this same area either recently or in the past?  N  Y

Please list below:

Procedure #1 \_\_\_\_\_ Surgeon \_\_\_\_\_ City \_\_\_\_\_ Date \_\_\_\_\_

Procedure #2 \_\_\_\_\_ Surgeon \_\_\_\_\_ City \_\_\_\_\_ Date \_\_\_\_\_

Current work status?  Regular  Light duty - (how long? \_\_\_\_\_)  Not working due to this problem  
 Disabled  Retired  Student

When is the last date you worked your regular job? \_\_\_\_\_

Are you currently receiving or plan to apply for: Disability:  Y  N Worker's Comp:  Y  N Unemployment:  Y  N