

# Patient Medical History – Please Complete This Entire Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Primary Care/Family Physician: \_\_\_\_\_

Who referred you? \_\_\_\_\_

Which doctor are you seeing today? Cople Emodi Franco Izadi  
Jana Keiser Pitner Smith

## CURRENT PROBLEM

Main reason for today's visit: \_\_\_\_\_ Left Right

Was there an injury or accident? No Yes → Describe: \_\_\_\_\_

When did symptoms begin or when was the date of injury? \_\_\_\_\_

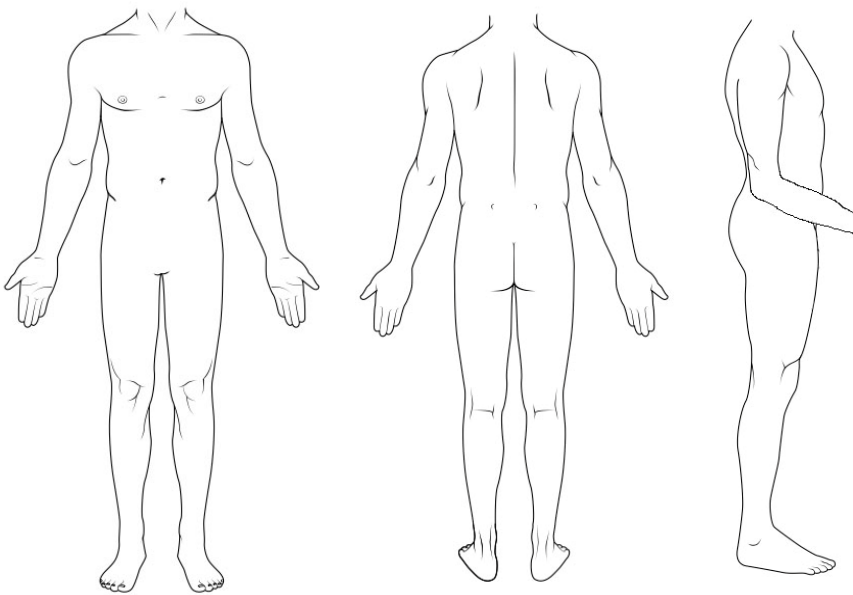
Are you feeling? Pain Stiffness Swelling Locking/Catching Weakness Instability

Are your symptoms? Improving Staying The Same Getting Worse

If you have pain, is it? Mild Moderate Severe

If you have pain, is it? Constant Intermittent

Please mark on the diagram where you are having pain with **XXX's**



Describe the Pain:

Burning

Stabbing

Aching

Tingling

Throbbing

Other \_\_\_\_\_

For this problem have you had previous?

X-Rays                      Where? \_\_\_\_\_ When? \_\_\_\_\_

MRI                              Where? \_\_\_\_\_ When? \_\_\_\_\_

Physical Therapy Where? \_\_\_\_\_ When? \_\_\_\_\_

Joint Injection Where? \_\_\_\_\_ When? \_\_\_\_\_

Is this a *worker's compensation* case?  No  Yes

Do you have an attorney helping with this case?  No  Yes

## PAST MEDICAL HISTORY

Check or list all of your **Medical Problems, Past or Current.**

- |                                      |  |   |  |
|--------------------------------------|--|---|--|
| <input type="checkbox"/> Asthma/COPD | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Prostate Disease     | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Fibromyalgia  | <input type="checkbox"/> Rheumatoid Arthritis | _____                                    |
| <input type="checkbox"/> Cancer      | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke               | _____                                    |
| <input type="checkbox"/> Depression  | <input type="checkbox"/> Hypertension  | <input type="checkbox"/> Stomach Ulcer/Reflux | _____                                    |

List your **Current Medications with Dosages** (include over-the-counter and herbal supplements).

_____	_____	_____
_____	_____	_____
_____	_____	_____

List any known **Allergies to Medications or Materials (Nickel, Latex, etc.)** and describe reaction.

No known drug allergies \_\_\_\_\_  
 \_\_\_\_\_

Have you or anyone in your family had a **severe reaction to anesthesia**?  No  Yes

If yes, describe: \_\_\_\_\_

Have you or anyone in your family had **excessive bleeding** after a procedure?  No  Yes

If yes, describe: \_\_\_\_\_

## PAST SURGICAL HISTORY

List Your **Prior Surgeries** - include approximate dates.

_____	_____	_____
_____	_____	_____
_____	_____	_____

## SOCIAL HISTORY

Occupation? \_\_\_\_\_

Are you?  Married  Single  Divorced  Widowed  Partnered

Do you exercise regularly or play sports?  No  Yes → Describe: \_\_\_\_\_

Do you live alone? No Yes

Where do you live? House Apartment Assisted Living Nursing Home

Number of stairs? \_\_\_\_\_ Is your bedroom on the main floor? No Yes

Do you smoke now? No Yes If yes, how many years? \_\_\_\_\_ How many packs per day? \_\_\_\_\_

Did you smoke in the past? No Yes

If yes, how many years? \_\_\_\_\_ How many packs per day? \_\_\_\_\_ When did you quit? \_\_\_\_\_

Do You Drink Alcohol? No Yes → If yes, how much per day? \_\_\_\_\_

### FAMILY HISTORY

Check or list all **Medical Problems of Family Members** ("blood relatives")

- |                                      |   |   |       |
|--------------------------------------|---|---|-------|
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Rheumatoid Arthritis | _____ |
| <input type="checkbox"/> Cancer      | <input type="checkbox"/> Hypertension   | <input type="checkbox"/> Stroke               | _____ |
| <input type="checkbox"/> Depression  | <input type="checkbox"/> Lung Disease   | <input type="checkbox"/> Stomach Ulcer        | _____ |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Auto-immune Disease  | _____ |

### HEALTH REVIEW

Please check if you have had any of the following symptoms in the **past month**.

- Dizziness Double Vision Headaches Ringing in the Ears Trouble Swallowing
- Shortness of Breath Chest Pain Irregular Heart Beat Cough
- Seizures Fainting Spells Memory Problems Depression Anxiety
- Diarrhea Constipation Stomach Pain Ulcers Reflux Nausea Vomiting
- Fever Unintended Weight Loss Fatigue Cold Intolerance Heat Intolerance
- Easy Bruising Rash Swelling Enlarged or Tender Lymph Nodes
- Frequent Urination Painful Urination Blood in Urine Abnormal Uterine Bleeding

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

The above information is accurate to the best of my knowledge

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

I have reviewed the above information with the patient

\_\_\_\_\_  
Physician/PA Signature

\_\_\_\_\_  
Date