

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:

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