PATIENT HISTORY FORM Name: _____ Date: ____/____/____

PLEASE STATE THE MAIN REASON FOR YOUR VISIT: _____

_____

_____

MEDICAL HISTORY: Please check all the conditions that YOU have had

_ hypertension	__ diabetes	__ osteoarthritis
_ osteoporosis	__ rheumatoid arthritis	__ lupus
_ scleroderma	__ gout	__ fibromyalgia
_ heart attack	__ heart failure	__ rheumatic fever
_ mitral valve prolapse	__ high cholesterol	__ asthma
_ pneumonia	__ bronchitis	__ emphysema
_ tuberculosis	__ peptic ulcer	__ esophageal reflux
_ Chron's disease	__ ulcerative colitis	__ irritable bowel
_ hepatitis	__ anemia	__ blood transfusion
_ thyroid disease	__ kidney failure	__ kidney stones
_ psoriasis	__ epileptic seizures	__ stroke
_ depression	__ syphilis	__ gonorrhea

_ cancer (please specify): _____

_ fractures and other accidents (please specify): _____

_ other (please specify): _____

ORTHOPEDIC SURGERY HISTORY: please list the procedures and your age at the time of surgery:

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

GENERAL SURGERY HISTORY: Please list the procedures and your age at the time of surgery:

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

MEDICATIONS: List the medications, vitamins, minerals and calcium supplements you are taking and dosage

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

MEDICATION ALLERGIES: List any medications you are allergic to and the symptoms you had.

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

PERSONAL/SOCIAL HISTORY: Marital status: _____ Children: _____ Work: _____

Tobacco use: _____ None _____ Smoke ___ packs per day for ___ years. ____ Quit _____ When _____

Alcohol use: ____ None ____ Socially ____1-2 drinks daily ____ 3 or more drinks daily

Recreational drugs: ____ None ____ Marijuana ____ Other

Exercise: ___ Do not exercise ____ Exercise ___ times per week, specify type: _____

FAMILY HISTORY: List any family history that you are aware of in the spaces below:

Mother: Living age ___ Problems: _____ Deceased age: ____ Cause: _____

Father: Living age ___ Problems: _____ Deceased age: ____ Cause: _____

Sisters and Brothers: Number: ____ Serious illness or cause of death _____

Children: Number: ____ Serious illness or cause of death _____

PATIENT HISTORY page 2 NAME: _____ DOB: _____

REVIEW OF SYSTEMS: Check the problems you are experiencing. If no problems exist, check NONE

GENERAL	__ None	__ fever	__ weight loss	__ weight gain
	__ chills	__ night sweats	__ fatigue	__ poor sleep
SKIN	__ NONE	__ rash	__ itching	__ photosensitivity
__ open wounds/sores		__ nodules	__ hair loss	__ insect bites
EYES	__ NONE	__ visual loss	__ dry eyes	__ red eyes
EARS	__ NONE	__ hearing loss	__ ear pain	__ ringing in ears
NOSE	__ NONE	__ sinus pain	__ runny nose	__ nosebleeds
THROAT	__ NONE	__ sore throat	__ cough	__ difficulty swallowing
MOUTH	__ NONE	__ dry mouth	__ sores in mouth	__ tooth loss
CARDIOVASCULAR		__ NONE	__ chest pain	__ palpitations
__ abnormal valve		__ abnormal beat	__ poor circulation	__ leg swelling
RESPIRATORY		__ NONE	__ shortness of breath	__ cough
__ pneumonia		__ bronchitis	__ sputum production	__ asthma
GASTROINTESTINAL		__ NONE	__ abdominal pain	__nausea
__ heartburn		__ vomiting	__ constipation	__ diarrhea
__ loss of appetite		__jaundice	__ gallstones	__ black tarry stools
ENDOCRINE		__ NONE	__ high blood sugar	__ increased appetite
__ heat tolerance		__ cold intolerance	__ increased thirst	__ frequent urination
__ menopausal symptoms				
GENITOURINARY		__ NONE	__ painful urination	__ difficult urination
__ blood in urine		__ kidney stones	__ recurrent infection	__ irregular periods
__ heavy periods		__ possible pregnancy	__ renal failure/insufficiency	
HEMATOLOGIC/LYMPHATIC			__ NONE	__ anemia
__ low white cells/platelets		__ swollen glands	__ easy bruising	__ recurrent bleeding
ALLERGIC/IMMUNOLOGIC		__ NONE	__ frequent infection	__ allergies
NEURO/PHYCH		__ NONE	__ headache	__ muscle weakness
__ seizures		__ fainting spells	__ dizziness	__ numbness/tingling
__ memory loss		__ poor concentration	__ anxiety	__ depression
MUSCULOSKELETAL		__ NONE	__ neck pain	__ back pain
__ trouble walking		__ bone fractures	__ accident trauma	__ muscle cramps
__morning stiffness		__ joint pain and swelling (list joints involved): _____		

PLEASE USE THE SPACE BELOW TO PROVIDE ANY ADDITIONAL INFORMATION: _____

PROVIDER SIGNATURE _____ PATIENT SIGNATURE _____ DATE _____