Patient History Form

Date of first appointment: ____/____/____ Time of appointment: _____

Name: _____ Birthdate: / /
LAST FIRST MIDDLE INITIAL MAIDEN

Address: _____ Age: _____ Sex: ␣F ␣M
STREET APT#

_____ Telephone: Mobile (____) _____
CITY STATE ZIP Home (____) _____

MARITAL STATUS: ␣Never Married ␣Married ␣Divorced ␣Separated Widowed

EMPLOYMENT STATUS: Occupation _____ Number of hours worked/average per week _____

Referred here by: (check one) ␣Self ␣Family ␣Friend ␣Doctor ␣Other Health Professional

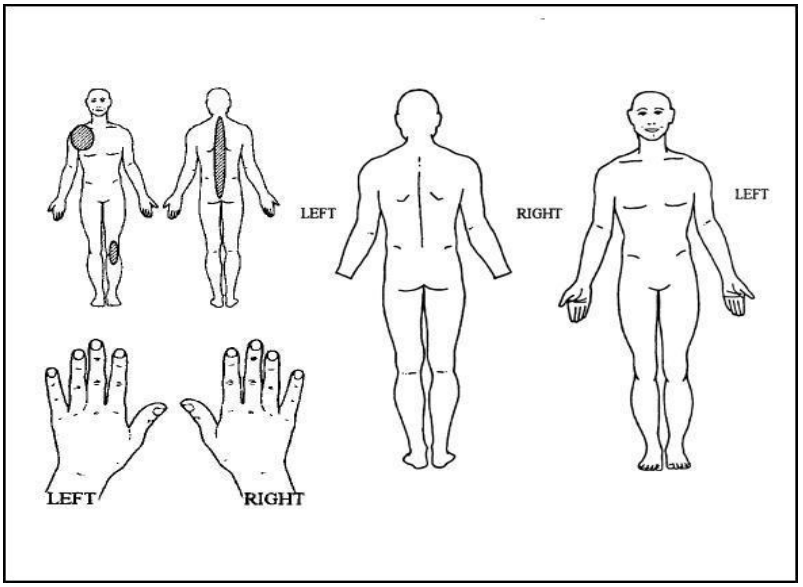
Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Describe briefly your present symptoms:

_____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.



Date symptoms began (approximate):

Diagnosis:

Previous treatment for this problem (include physical therapy, surgery and injections;

medications to be listed later)

_____

_____

_____

Please list the names of other practitioners you have seen for this problem:

_____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

Have you or a blood relative had any of the following? Check if "yes"

Yourself		**Relative Name/Relationship**	**Yourself**		**Relative Name/Relationship**
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Psoriasis/ PSA			Osteoporosis	

Patient's Name _____ Date _____ Physician Initials

SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last eye exam _____/_____/_____ Date of last chest x–ray _____/_____/_____

Date of last Tuberculosis Test_____/_____/_____ Date of last bone densitometry _____/_____/____

Constitutional

- ❑ Recent weight gain amount _____
- ❑ Recent weight loss amount _____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

Eyes

- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears-Nose–Mouth–Throat

- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Difficulty in swallowing

Cardiovascular

- ❑ Pain in chest
- ❑ Irregular heartbeat
- ❑ High blood pressure
- ❑ Respiratory
- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Stomach pain
- ❑ Increasing constipation
- ❑ Diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genitourinary

- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, “smoky” urine
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers

Musculoskeletal

- ❑ Morning stiffness

  Lasting how long?
  Minutes Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling

List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)

- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

Neurological System

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Numbness or tingling
- ❑ Memory loss
- ❑ Night sweats

Psychiatric

- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine

- ❑ Excessive thirst

Hematologic/Lymphatic

- ❑ Swollen glands
- ❑ Tender glands
- ❑ Transfusion/when
- ❑ Allergic/Immunologic
- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

Patient’s Name _____ Date _____ Physician Initials

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day?

Do you smoke? ▫ Yes ▫ No ▫ Past – How long ago?

Do you drink alcohol? ▫ Yes ▫ No Number per week

Has anyone ever told you to cut down on your drinking?

❑ Yes ▫ No

Do you use drugs for reasons that are not medical? ▫ Yes ▫ No

If yes, please list:

_____

Do you exercise regularly? ▫ Yes ▫ No

Type

Amount per week

How many hours of sleep do you get at night?

Do you get enough sleep at night? ▫ Yes ▫ No

Do you wake up feeling rested? ▫ Yes ▫ No

PAST MEDICAL HISTORY

Do you now or have you ever had: *(check if "yes")*

❑	Cancer	▫ Heart problems	▫ Asthma
❑	Goiter	▫ Leukemia	▫ Stroke
❑	Cataracts	▫ Diabetes	▫ Epilepsy
❑	Nervous breakdown	▫ Stomach ulcers	▫ Rheumatic fever
❑	Bad headaches	▫ Jaundice	▫ Colitis
❑	Kidney disease	▫ Pneumonia	▫ Psoriasis
▫	Anemia	▫ HIV/AIDS	▫ High Blood Pressure
❑	Emphysema	▫ Glaucoma	▫ Tuberculosis

Other significant illness (please list)

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

Previous Operations

Type	*Year*	*Reason*
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ▫ No ▫ Yes Describe:

Any other serious injuries? ▫ No ▫ Yes Describe:

Patient's Name Date Physician Initials

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings_____ Number living_____ Number deceased_____

Number of children_____ Number living_____ Number deceased_____ List ages of each _____

Health of children: _____

MEDICATIONS

Drug allergies: ▫ No ▫ Yes To what? _____

Type of Reaction: _____

Preferred Pharmacy: _____

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A Lot	Some	Not at All
1.			▫	▫	▫
2.			▫	▫	▫
3.			▫	▫	▫
4.			▫	▫	▫
5.			▫	▫	▫
6.			▫	▫	▫
7.			▫	▫	▫
8.			▫	▫	▫
9.			▫	▫	▫
10.			▫	▫	▫

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