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NEW PATIENT MEDICAL HISTORY

Patient name:_____ **Date of Birth:** _____

1. Which is your dominant hand? R L Ambidextrous
2. What is your main complaint?

_____

_____

_____

3. Is this the result of a Work Injury? No Yes
IF YES, date and time of injury? ____/____/____
4. Is this the result of a Motor Vehicle Accident? No Yes
IF YES, date and time of accident? ___/____/____
Describe this incident: ☐Head-on ☐Rear-Ended ☐T-boned
☐Other:_____
☐Driver ☐Passenger Front Seat ☐Passenger Back Seat ☐Loss of consciousness
☐Airbags deployed ☐Seatbelt ☐Ambulance: ☐C-collar or ☐Backboard
Name of ER: _____
5. If you answered NO to questions 3 and 4, please describe how your illness or injury occurred:

_____

_____

6. Have you had anything similar before? No Yes **If Yes**, please explain:_____
7. Prior to this episode, were you completely symptom free? Yes No **If No**, please explain:_____
8. What doctors have you seen for this problem? _____
9. Please answer the following pain-related questions:
Pain Scale: **0 is no pain, 10 is the worst pain you have ever had**
What is your pain level now? 1 2 3 4 5 6 7 8 9 10
In the last 30days, what has your pain been at its best? 1 2 3 4 5 6 7 8 9 10
In the last 30 days, what has your pain been at its worst? 1 2 3 4 5 6 7 8 9 10
How frequent is your pain? ☐Constant ☐Intermittent Explain:_____
How long does your pain last? ☐Less than 1 hour ☐Less than 1 day☐All day ☐All night
Is your pain getting: ☐Better ☐Worse ☐Not changing

	Worsens Pain	**Relieves Pain**	**No Effect On pain**		**Worsens Pain**	**Relieves Pain**	**No Effect On pain**
Sitting				Standing			
Rising from sitting				Driving			
Walking				Coughing/sneezing			
Bending forward							
Bending backward							
Bending to the side							

TESTING AND TREATMENTS;

Which of the following tests have been done for your condition?

- ☐X-ray Date: ___/___/___ Facility _____
- ☐MRI Date: ___/___/___ Facility _____
- ☐CT Scan Date: ___/___/___ Facility _____
- ☐Bone Scan Date: ___/___/___ Facility _____
- ☐EMG Date: ___/___/___ Facility _____
- ☐Other:_____Date: ___/___/___ Facility _____

Please indicate any treatments you have had for your **present** injury and their effect:

	Not Helpful	Helpful	How long it helped?	When?
☐Physical Therapy	☐	☐	_____	_____
☐Hot Packs	☐	☐	_____	_____
☐Ice	☐	☐	_____	_____
☐TENS/E Stim	☐	☐	_____	_____
☐Traction	☐	☐	_____	_____
☐Exercises	☐	☐	_____	_____
☐Acupuncture	☐	☐	_____	_____
☐Massage	☐	☐	_____	_____
☐Chiropractic	☐	☐	_____	_____
☐Epidural Injection	☐	☐	_____	_____
☐Trigger Point Injection	☐	☐	_____	_____
☐Facet Block	☐	☐	_____	_____
☐Bracing	☐	☐	_____	_____
☐Psychological Treatment	☐	☐	_____	_____

PAST MEDICAL HISTORY

Do you or have you had any problems with the following: (check all that apply)

- ☐Alcohol Abuse ☐Cholesterol ☐Heart Disease ☐Liver Disease
- ☐Arthritis-Osteoarthritis ☐Drug Abuse ☐Hepatitis ☐Stroke/TIA
- ☐Arthritis-Rheumatoid ☐Diabetes ☐HIV/AIDS ☐Thyroid
- ☐Asthma ☐Fibromyalgia ☐Hypertension ☐Other_____
- ☐Cancer ☐GERD (Reflux) ☐Kidney Disease ☐Other_____
- ☐Past Work Injury-Date:_____
- ☐Past Motor Vehicle Accident-Date:_____

Please list surgeries you have had: Date:

_____ _____

_____ _____

_____ _____

FAMILY HISTORY-Please check any diseases/disorders that **run in your family. DO NOT INCLUDE YOURSELF.**

	Relative		Relative		Relative
☐Heart Disease	_____	☐Arthritis	_____	☐Hypertension	_____
☐Alcohol abuse	_____	☐Diabetes	_____	☐Drug Abuse	_____
☐Cancer	_____	☐Other	_____		

SOCIAL HISTORY

☐Married ☐Single ☐Separated ☐Divorced ☐Widowed Number of children_____

1. Do you smoke? ☐No ☐Yes If Yes:Packs/day_____How many years_____ ☐Quit When? _____
2. Do you drink alcoholic beverages? ☐No ☐Yes If yes, how much per day?_____ Per week? _____
3. Do you use or have you used street drugs? ☐No ☐Yes
   If yes, what kind and when? _____

EMPLOYMENT STATUS

1. Job Title/Occupation _____
2. Briefly describe your job duties:
   _____
3. Are you currently under work restrictions ☐No ☐Yes **If yes,** what are your restrictions?
   _____
4. Please check current work status:
   ☐Working Full Time: Hours worked per day _____Days worked per week _____
   ☐Working Part Time: Hours worked per day _____Days worked per week _____
   ☐Working Light Duty:Hours worked per day _____Days worked per week _____
   ☐Off Duty Due to Injury: Date last worked:_____
   ☐Retired/Not working

ACTIVITIES OF DAILY LIVING: Please check the level you are **presently able to complete** the following activities:

	Unable	Independent	Need some Assistance		Unable	Independent	Need some Assistance
Walk	☐	☐	☐	Feed yourself	☐	☐	☐
Dress	☐	☐	☐	Clean house	☐	☐	☐
Bathe	☐	☐	☐	Care for family	☐	☐	☐
Drive	☐	☐	☐				

1. Are there other limitations due to current condition? _____
2. At one time, how long can you: Sit_____Stand_____Walk_____
3. Do you use a ☐Straight Cane ☐Quad Cane ☐Walker ☐Wheelchair
4. Prior to your injury/illness was your ability to do things at all limited? ☐No ☐Yes
   If yes, please explain: _____
5. Are there stairs to enter/or in your home? ☐No ☐Yes How many?_____
   Is there a rail? _____

REVIEW OF SYSTEMS

Do you have problems with any of the following? Please check all that apply.

General
☐Fatigue
☐Weakness
☐Trouble sleeping

Skin
☐Rashes
☐Dryness
☐Color changes
☐Hair/nail changes

Head
☐Headache

Circulation
☐Discoloration of feet/legs
☐Sores/ulcers on feet/legs
☐Swelling of ankles/legs
☐Calf pain with walking
☐Leg cramps
☐Varicose veins

Gastrointestinal
☐Difficulty swallowing
☐Heartburn
☐Unexplained nausea/vomiting
☐Change in bowel habits

Hematology
☐Unexplained fevers
☐Ease of bruising
☐Ease of bleeding

Psychiatric
☐Nervousness
☐Depression
☐Anxiety
☐Memory loss
☐Stress
☐Bipolar Disorder
☐Other psychological

- Head Injury

Eyes/Ears/Nose/Throat
- Blurry or double vision
- Eye pain
- Blindness
- Ear pain
- Ringing in ears
- Deafness
- Nosebleeds
- Dry mouth
- Sore throat/hoarseness
- Non-healing sores

Neck
- Stiffness
- Swollen glands
- Pain

Cardiac
- Palpitations
- Chest discomfort at rest
- Chest discomfort with activity
- Constipation
- Diarrhea
- Blood in stool
- Loss of bowel control
- Abdominal pain

Genitourinary
- Frequent urination
- Painful urination
- Loss of bladder control

Musculoskeletal
- Muscle or joint pain
- Stiffness
- Back pain
- Redness of joints
- Swelling of joints
- Trauma

Metabolism/Endocrine
- Heat or cold intolerance
- Excessive sweating
- Increased thirst
- Change in appetite
- Recent unexplained weight change

diagnosis_____

Women Only
- Currently pregnant
- Breastfeeding

Nervous System
- Dizziness
- Fainting
- Seizures
- Numbness/tingling

Respiratory
- Wheezing
- Shortness of breath with normal activity
- Shortness of breath with exertion
- Cough-wet,dry,productive
- Coughing up blood

Reviewed by:

_____

Date: ____/____/_____

MEDICATION INTAKE SHEET

Please list **all** medications taken on a daily basis, including **vitamins, herbals and over-the-counter medications.** Please list all **medication allergies.** Please list pharmacy name and telephone number.

MEDICATION NAME	DOSE/STRENGTH	TIMES TAKEN PER DAY	WHO PRESCRIBES

Are you taking any blood thinners/anticoagulants, such as:

Warfarin (coumadin)	Aspirin	Plavix (clopidogrel)
Aggrenox (aspirin & dipyvidamole)	Defibrotide	Dipyridamole
Effient (prasugrel)	Ticagrelor (brilinta)	Ticlopidine
Lovenox (enoxaparin)	Argatroban	Bivalirudin (angiomax)
Pradaxa (Dabigatran Etexilate)	Desirudin (Iprivask)	Lepirudin (refludan)
Xarelto (rivaraxaban)	Arixtra (fondaparinox)	Apixaban

Pharmacy Name: _____Phone Number: _____

Please list any medications you have tried in the past for this <u>CURRENT</u> problem:

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication :_____ Who Prescribed: _____

ALLERGIES TO MEDICATIONS: _____