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NEW PATIENT MEDICAL HISTORY

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name: *(Last, First, M.I.)* ☐ M ☐ F		**DOB:**	**Age:**
Contact Phone #:	**Occupation:**	**Height:**	**Weight:**
Referring Physician: *(Name, Address, Phone)*			
Primary Physician: *(Name, Address, Phone)*			
Pharmacy: *(Name, Address, Phone)*			

REASON FOR TODAY'S VISIT

What is the reason for today's visit? (Please check) ☐ Left ☐ Right

When did the injury occur? **Hand Dominance:** ☐ Left ☐ Right

Was the injury related to Work? ☐ Yes ☐ No **Auto Accident?** ☐ Yes ☐ No

If yes, please explain:

Current pain level: (please circle) *(least severe)* **0 1 2 3 4 5 6 7 8 9 10** *(most severe)*

When does the pain occur? ☐ At rest ☐ With activity ☐ At night ☐ Other: ______________________________

Describe the pain: ☐ Dull ☐ Sharp ☐ Constant ☐ Intermittent ☐ Shooting ☐ Burning ☐ Tingling ☐ Throbbing

Associated symptoms: ☐ Swelling ☐ Bruising ☐ Clicking ☐ Locking ☐ Weakness ☐ Numbness ☐ Other:_________________

What makes you symptoms better? ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Braces ☐ Injections ☐ Physical Therapy ☐ Medication *(specify)* __________________________ ☐ Other: ____

What makes you symptoms worse?

Does the pain wake you up at night? ☐ Never ☐ Rarely ☐ Occasionally ☐ Every night

Any Prior treatment for this injury? ☐ Yes ☐ No *(if yes, please specify)* ____

Any Prior imaging for this injury? ☐ Yes ☐ No *(if yes, please specify)* ____

Are you allergic to any medication? ☐ Yes ☐ No

Name the Drug	Reaction You Had

PAST MEDICAL HISTORY

Please CIRCLE any of the conditions you have had in past or have currently.

Cardiovascular	**Respiratory**	**Orthopedic**	**Neuro/Psych**
Hypertension Hypercholesterolemia History of a Blood Clot Heart Disease: Angioplasty Bypass Surgery Pacemaker Congestive Heart Failure Stroke Anemia	Asthma COPD Sleep Apnea **Gastrointestinal** Esophageal Reflux Gastric Ulcer Liver Disease	Arthritis Gout Osteoporosis Lyme Disease Rheumatoid Arthritis **Endocrine/Hematologic** Hypothyroidism Hyperthyroidism HIV Infection History of Cancer	Migraine Headache Seizures Depression Anxiety Bipolar Disorder Alcohol/Drug Dependence **Renal/GU** Kidney Disorder Prostate Disorder STD

Other Medical Conditions: ____

Is there a chance that you are pregnant? ☐ Yes ☐ No Last Menstrual Period: ____________________

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Any non-medication allergies?

Name the Allergen	Reaction You Had

SURGICAL HISTORY

Please list all prior surgeries and dates: ☐ None		

FAMILY HEALTH HISTORY

Medical Conditions in you immediate family: *(list illness and relative it affect)*

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Tobacco Use: ☐ Never ☐ Former Smoker (Years used:________) ☐ Current Smoker (Packs per day: _______)

Alcohol Use: ☐ None ☐ Socially ☐ 1 drink/day ☐ 2-3 drinks/day ☐ 4 or more drinks/day **Drug Use:** ______________________

REVIEW OF SYSTEMS

Have you experienced any of the following symptoms over the past 6 months?

☐ Weight Gain	☐ Shortness of Breath	☐ Nausea	☐ Skin Rash	☐ Numbness	☐ Depression
☐ Weight Loss	☐ Chest Pain	☐ Vomiting	☐ Easy Bleeding/Bruising	☐ Weakness	☐ Fatigue
☐ Fever/Chills	☐ Heartburn	☐ Diarrhea	☐ Dizziness	☐ Joint Stiffness	☐ Anxiety
☐ Cough	☐ Urinary Symptoms	☐ Abdominal Pain	☐ Incontinence	☐ Joint Pain	☐ Other: ________

I certify that the above is correct and complete to the best of my knowledge.

Patient Signature: ____ Date: ______________

WORKER'S COMPENSATION & NO FAULT

If this problem is related to a work or car accident, please complete the following:

☐ **Work related** ☐ **Car Accident related** **Date of accident/onset:** ______________________________

What part(s) of your body was injured (include side)? ______________________________

Prior to this accident, did you have a problem/pain in the affected area? ______________________________

Did you sustain other injuries due to this accident? ___________ **If yes, please give details:**

____

How did the accident occur:

____

____

____

Did you have immediate pain in the affected area at the time of the accident or a few days later? ______________________________

Job title on the date of injury: ______________________________

What were your usual work activities on the date of the injury/onset? ______________________________

Employer when injury occurred (include address and phone#): ______________________________

____

Have you been treated by another health care provider for this injury? If so, provide details: ______________________________

____

Are you currently working? ____________ **If yes, regular or modified duties (if modified, give details)?** ______________________________

____

If you are NOT working, what is the date you first missed work due to this injury? ______________________________

Are you being counseled by a lawyer for this injury? ______________________________

If it was a car accident, were you the driver or a passenger? ______________________________

Did the air bag deploy? ______________________ **Were you wearing your seat belt at the time of the accident?** _________________

______________________________ ______________________________

Signature **Date Completed**