GEORGE P. ACKERMAN, M.D.

NEW PATIENT MEDICAL HISTORY

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

Primary Physician: _____ **Age:** _____
Pharmacy: (Name, Address) _____ **Height:** _____
How did you hear about us? _____ **Weight:** _____

REASON FOR TODAY'S VISIT

What is the reason for today's visit? (Include Right or Left) _____
When did you symptoms start?_____ **Dominant Hand:** ☐ Right ☐ Left
Current pain level: (please circle) (least severe) 0 1 2 3 4 5 6 7 8 9 10 (most severe)
When do the symptoms occur? _____ **Associated symptoms:** _____
What makes you symptoms better? _____ **Prior treatment for this injury:** _____
Did this injury occur at work? ☐ Yes ☐ No **Auto Accident?** ☐ Yes ☐ No **School Injury?** ☐ Yes ☐ No

PAST MEDICAL HISTORY

Medical Conditions: _____
Previous Surgeries: (Include date) _____
Current Medications: _____
Drug Allergies: (Include reaction) _____
Family Medical History: (Include condition and relative) _____
Social History: **Alcohol Use:** ☐ None ☐ Occasionally ☐ Daily ☐ Heavy **Drug Use:** ☐ None ☐ _____
Tobacco Use: ☐ Never ☐ Current (Packs per day: _____) ☐ Former (Years: _____ to _____)

Review of Symptoms: (Have you experienced any of the following over the past 6 months?)

Fever/Chills	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Blurred Vision	☐ Yes ☐ No	Heartburn	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Nose Bleeds	☐ Yes ☐ No	Joint Stiffness	☐ Yes ☐ No	Easy Bleeding	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No	Blood Clot/DVT	☐ Yes ☐ No

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

Patient Signature: _____ **Date:** _____ **Physician Signature:** _____

(This section is for physician use only)

Exam: **Imaging:**

A/P:

Physician Signature: _____