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Date: _____

FOR INTERNAL USE ONLY
ACCT# _____
Patient DOB:_____
Reviewed by: _____

General Information/Medical History

This information is very important and will help us give you the best medical care possible. Please answer as completely and accurately as possible.

Patient's Last Name:	**First Name:**	**Age:**
Date of Injury/Onset:	**Work-related?** ❑Yes ❑ No **If work-related, was this reported to your supervisor?** ❑Yes ❑ No	**Related to Automobile Accident?** ❑Yes ❑ No
Related to a liability? ❑Yes ❑ No	**School-related injury?** ❑Yes ❑ No	**Sport-related injury?** ❑Yes ❑ No If yes, sport? _____
Sport-Related Injuries Only!		
School:	**Coach's Name:**	**Athletic Trainer's Name:**

Side ❑ Right ❑ Left ❑ Both	**Body Part:**	**Seen for this injury by another medical provider:** ❑Yes ❑ No If yes, provider's Name: _____	**Previous tests for this problem:** ❑ x-ray ❑ MRI ❑ Other _____
Previous treatments for this problem: Please indicate any previous treatment and if it made you better, worse or no change ❑Physical Therapy: ❑better ❑worse ❑no change ❑ Chiropractor: ❑better ❑worse ❑no change ❑Medications: ❑better ❑worse ❑no change ❑ Other things that have made you better_____ / worse_____			
Are you pregnant or is there any possibility you could be pregnant? ❑Yes ❑ No			

Past Medical History: Check all that apply ❑ No history of any of the below

General
- ❑ bleeding disorder
- ❑ diabetes mellitus:
  - ❑ type I ❑ type II
- ❑ thyroid problem
  - ❑ high ❑ low
- ❑ cancer - type: _____
- ❑ methicillian resistant staphylococcus aureus **(MRSA)**
- ❑ 2 or more falls in past 12 months or any fall with injury in the past 12 months

Gastrointestinal:
- ❑ hepatitis/liver disease
- ❑ ulcers
- ❑ hiatal hernia
- ❑ bowel disorder
- ❑ gastritis

Genitourinary:
- ❑ urinary infections
- ❑ venereal disease
- ❑ kidney disease
- ❑ kidney stones

Neurologic:
- ❑ seizures/epilepsy
- ❑ paralysis
- ❑ stroke
- ❑ polio
- ❑ reflex sympathetic distrophy **(RSD)**

Respiratory:
- ❑ rheumatic fever
- ❑ tuberculosis
- ❑ pleurisy/pneumonia
- ❑ asthma
- ❑ emphysema
- ❑ COPD

Cardiovascular
- ❑ heart disease
- ❑ heart attack
- ❑ hypertension (high blood pressure)
- ❑ mitral valve prolapse
- ❑ thrombophlebitis (e.g. blood clots in legs)
- ❑ irregular heart beat (e.g. atrial fibrillation)
- ❑ high cholesterol (hypercholesterolemia)
- ❑ other: _____
- ❑ Do you have a cardiologist? ❑Yes ❑ No
  Cardiologist's name: _____

Musculoskeletal
- ❑ arthritis – type: _____
- ❑ gout
- ❑ serious injury/fracture
- ❑ rheumatologic condition (lupus/psoriasis/Reiter's syndrome/ ankylosing spondylitis)
- ❑ fibromyalgia
- ❑ previous fracture
- ❑ osteoporosis: date of last **Dexa** scan:_____ facility_____/ordering provider:_____

Psychiatric
- ❑ depression
- ❑ anxiety
- ❑ other:_____

Please elaborate on the above responses. Please include any and all information that the doctor needs to give you the best care possible.

Review of Systems: Please check all that you <u>currently</u> have ❑ Not currently experiencing any of the below

General
- ❑ unexplained weight change
- ❑ fever or chills
- ❑ night sweats
- ❑ frequent urination
- ❑ lumps or masses
- ❑ dizziness or fainting
- ❑ itching or rash

Gastrointestinal:
- ❑ dysphagia (difficulty in swallowing)
- ❑ nausea or vomiting
- ❑ jaundice (yellow eyes/skin)
- ❑ blood in stools
- ❑ heartburn

Cardiovascular:
- ❑ chest pain
- ❑ palpitations

Genitourinary:
- ❑ incontinence (loss of control of urine/stool)
- ❑ menopause
- ❑ burning with urination
- ❑ difficulty urinating

# of times you urinate at night_____

Neurologic:
- ❑ numbness
- ❑ weakness

Ear/Eye/Nose/Throat
- ❑ visual change
- ❑ hearing change
- ❑ tinnitus
- ❑ dentures
- ❑ bleeding gums
- ❑ hoarseness

Respiratory:
- ❑ cough/sputum
- ❑ shortness of breath

Musculoskeletal:
- ❑ backache
- ❑ joint pain
- ❑ joint swelling

Breast:
- ❑ lumps, pain, nipple discharge

date of last mammogram:_____

Please elaborate on the above responses. Please include any and all information that the doctor needs to give you the best care possible.

Past Surgeries: Please list <u>all</u> past surgeries in chronological order- include tonsils, appendix, gallbladder, etc.

Type of Surgery	Surgeon	Date/Yr		Type of Surgery	Surgeon	Date/Yr
1.				2.		
3.				4.		
5.				6.		
7.				8.		
9.				10.		

Antibiotics required before surgery? ❑Yes ❑ No

Allergy or past reaction to any anesthesia? ❑Yes ❑ No If yes, please elaborate:_____

_____

Allergies/Reactions: Please list all medicines/substances. ❑ No known allergies

Allergy	Type of Reaction		Allergy	Type of Reaction
1.			2.	
3.			4.	
5.			6.	
7.			8.	
9.			10.	

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Medications: Please list all medications you are currently taking- include over the counter.

Medicine	Dosage	How Often	Prescribed by:		Medicine	Dosage	How Often	Prescribed by:
1.					**2.**			
3.					**4.**			
5.					**6.**			
7.					**8.**			
9.					**10.**			

Social History: Please check or fill in all applicable blanks.

Do you live alone? ❑Yes ❑ No	**Number of Children:**	**Number of pets:**	**Exercise:** ❑Daily ❑ Weekly ❑ Monthly ❑ Rarely ❑ Never
Hobbies/Activities:			
Currently using tobacco (smoke/chew)? ❑Yes ❑ No packs or cans/day:_____ years:_____	**Quit using tobacco?** date you quit: _____		**Previously used tobacco?** ❑Yes ❑ No packs or cans/day:_____ years:_____
Alcohol consumption? ❑Yes ❑ No #drinks/week:_____	**Recreational drug use:** ❑Yes ❑ No type: _____		**Hand Dominance:** ❑Left ❑ Right ❑ Ambidextrous

Family Medical History: Please list all medical illnesses affecting your immediate family - includes parents, brothers or sisters.

Family Member	Age	Living	Deceased	Medical Problems:
Mother		☐	☐	
Father		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

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

_____ _____

Signature of Patient or Authorized Representative Date

_____

Print Name

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Provider Signature:_____