PATIENT HISTORY FORM

Date: ______________________

NAME:____ AGE:________ Sex: M_____ F_____

How were you referred to our office? **Physician** ____ **Magazine** ____ **Internet** ____ **Newspaper** ____ **TV** ____ **Other** _____

Name of Referring Physician: ____

Your Primary Care Physician: ____ Cardiologist: ______________________________

CHIEF COMPLAINT
REASON FOR TODAY'S VISIT: ____

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WHEN DID YOUR INJURY OR PROBLEM BEGIN? _______________
DO YOU CONSIDER THIS WORK RELATED: _____ Yes _____ No When was it reported to your employer? _____________

PATIENT MEDICAL HISTORY
LIST ANY MEDICAL PROBLEMS YOU HAVE: ____

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LIST ALL MEDICATION YOU ARE TAKING

NAME OF MEDICATION	DOSE	HOW OFTEN	REASON

DO YOU HAVE ANY ALLERGIES? ____ Yes _____NO
ASPIRIN _____ SULFA _____ PENICILLIN ______ ANESTHETIC _____LATEX_____OTHER__________________________

PAST SURGERIES: ____

Any Anesthesia problems____

FAMILY HISTORY
What illnesses run in your family? ____

SOCIAL HISTORY
Are you : Right_____ or Left _____ handed?

Occupation: ____________________________ Employed by: ____

Married _____ Widowed _____ Divorced _____ Separated _____ Single_____ How many children? _________

How much do you Smoke? _____________________ How much Alcohol do you Drink? ________________________

Have you ever used street drugs? Yes _____ No _____If so when was the last time?________________What drug?______________

Do you exercise? Yes _____ No _____

Recent weight gain? Yes________ No________ Recent Weight Loss? Yes_______ No_______ Intentional ? Yes_____No_____

Do you use a: Wheelchair ______ Walker _____ Cane _____ Who do you live with? _________________________________