



Patient History Form

NAME: _____ TODAY'S DATE: _____

SS#: _____ DATE OF BIRTH: _____

Why are you seeing the doctor today? _____

Current problem is the result of (check all that apply):

Work Accident: _____ Car Accident: _____ Accident: _____ Other: _____

This occurred during (check all that apply):

Lifting: _____ Reaching: _____ Pulling: _____ Squatting: _____ Pushing: _____

Hit by object: _____ Twisting: _____ Falling: _____ Bending: _____ Not known: _____

MEDICATION	DOSAGE	HOW LONG?	SIDE EFFECTS

ALLERGIES

REVIEW OF SYSTEMS

Are you currently having or have you had problems with your:

	CIRCLE		DESCRIBE ALL YES RESPONSES
Eyes	NO YES		_____
Ears, Nose, Throat	NO YES		_____
Lungs, Breathing	NO YES		_____
Digestion	NO YES		_____
Bowel movement	NO YES		_____
Bladder problem	NO YES		_____
Diabetes	NO YES		_____
High blood pressure	NO YES		_____
Bleeding problems	NO YES		_____
Balance problems	NO YES		_____
Numbness/Tingling	NO YES		_____
Blackout/Fainting	NO YES		_____
Psychological problems	NO YES		_____
AIDS	NO YES		_____
Cancer	NO YES		_____
Arthritis	NO YES		_____
Polio	NO YES		_____
Tuberculosis (TB)	NO YES		_____
Epilepsy	NO YES		_____

Reviewed by: _____, D.O./M.D. Date: _____

PAST MEDICAL HISTORY

SURGERIES/HOSPITALIZATIONS	YEAR	COMPLICATIONS

Have you ever had general anesthesia? NO _____ YES _____
 If yes, did you have any problems? NO _____ YES _____ Describe: _____

FAMILY HISTORY

FAMILY MEMBER	ALIVE	DECEASED	AGE	HEALTH STATUS/CAUSE OF DEATH
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

SOCIAL HISTORY

Work in the home: _____ Employed (occupation): _____ Student: _____
 Single: _____ Married: _____ Divorced: _____ Separated: _____ Widowed: _____
 Children: No: _____ Yes: _____ Number of Children: _____
 Do you live alone? No: _____ Yes: _____
 Do you exercise: Daily: _____ Weekly: _____ Monthly: _____ Rarely: _____ Never: _____
 What type of exercises? _____
 Are you on a special diet? No: _____ Yes: _____ Describe: _____
 History of substance abuse? No: _____ Yes: _____ Describe: _____
 Smoke currently? No: _____ Yes: _____ _____ packs per day for _____ years.
 Quit smoking? This year: _____ > 1 year: _____ > 5 years _____ > 10 years _____
 Previously smoked: _____ packs per day for _____ years.
 Drink alcohol? Daily: _____ 1-2 x/week: _____ 1-2 x/month: _____ 1-2 x/year: _____

Reviewed by: _____, D.O./M.D. Date: _____
 Reviewed by: _____, D.O./M.D. Date: _____
 Reviewed by: _____, D.O./M.D. Date: _____