

HEALTH HISTORY

Date: _____

Name _____ Age _____ Were you referred by a Physician? Yes _____ No _____

Who requested our services? _____ Family Physician _____

Reason for seeking medical attention _____ Right Left Both

Date of injury or duration of symptoms _____ Work related? Yes _____ No _____ Are your right or left handed? _____

Have you had any diagnostic studies for this condition, such as MRI, Bone Scan, etc? Please list _____

Have you seen anyone else regarding this condition? Yes _____ No _____ If yes, list names and dates _____

Have you ever been diagnosed with any of the following medical conditions:

	Yes	No		Yes	No		Yes	No
Asthma	_____	_____	Rheumatoid Arthritis	_____	_____	Osteoarthritis	_____	_____
Kidney Disease	_____	_____	Anemia	_____	_____	Alcoholism	_____	_____
Lupus	_____	_____	Migraines	_____	_____	Sickle Cell Disease	_____	_____
Bleeding Tendencies	_____	_____	Cancer	_____	_____	Colitis	_____	_____
Heart Disease	_____	_____	Diabetes	_____	_____	Stroke	_____	_____
Epilepsy	_____	_____	Goiter	_____	_____	Stomach Ulcers	_____	_____
High Blood Pressure	_____	_____	Lung Disease	_____	_____	Depression/Anxiety	_____	_____
Polio	_____	_____	Nervous System Disorder	_____	_____	Pelvic Radiation	_____	_____
Hepatitis	_____	_____	Tuberculosis	_____	_____	COPD	_____	_____

(Chronic Obstructive Pulmonary Disease)

Other Medical Conditions: _____

Are there law suits pending on your orthopaedic condition? _____

Please list any orthopaedic surgeries and dates:

Please list any other surgeries and dates:

Please list all current medications and dosages:

Are you allergic to: (check if you are)

Latex _____ Penicillin _____ Cephalosporin _____ Mycins _____ Sulfa _____ Tetanus _____ Iodine _____
Dyes _____ Aspirin _____ Codeine _____ Morphine _____ Adhesive Tape _____ Arthritis Medicine _____

Foods (please list) _____

Others: _____

Please explain allergic reaction: _____

Do you currently use tobacco: Cigarettes _____ Pipe _____ Smokeless _____ Amount per day: _____ Quit when? _____

Do you drink alcohol: Beer _____ Liquor _____ Wine _____ Amount per day: _____ or per week: _____

What is your current occupation? _____

Has anyone in your family had:

High Blood Pressure _____ Heart Disease _____ Cancer* _____ Diabetes _____ Bleeding Problems _____ Lung Disease _____
*if yes, what type of cancer?

Have you recently had any of the following problems or symptoms:

	Yes	No		Yes	No		Yes	No
Chest Pain	_____	_____	Irregular Heart Beat	_____	_____	Fainting Spells	_____	_____
Breathing Difficulties	_____	_____	Cough	_____	_____	Cough with Blood	_____	_____
Numbness or Tingling	_____	_____	Dizziness	_____	_____	Headaches or Migraines	_____	_____
Vision Changes	_____	_____	Fever or Chills	_____	_____	Unexpected Weight Loss	_____	_____
Abdominal Pain	_____	_____	Nausea or Vomiting	_____	_____	Diarrhea	_____	_____
Bloody or Black Tarry Stools	_____	_____	Loss of Control of Bowels	_____	_____	Difficulty Starting Urine	_____	_____
Pain or Burning on Urination	_____	_____	Blood in Urine	_____	_____	Loss of Control of Bladder	_____	_____

Patient Signature _____ Physician's Signature _____ Date: _____

(I have reviewed this information with the patient)

Ht. _____ Wt. _____ Blood Pressure: _____ / _____ Pulse _____