

# PATIENT HISTORY

**PATIENT NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_  
**TODAY'S DATE:** \_\_\_\_\_

For each of the following please use an **X** if the item applies to you or did in the past. If an items applies to you fill in the details that follow it. If you have any X-rays, Cat Scans, or MRI's related to the problem for which you are being seen, please bring at least copies of the reports with you on your first visit. If there are reports from other doctors or the ER related to your problem for which you are being seen these too need to be brought with you. Finally, if the visit is because of a new motor vehicle accident, please bring a copy of your accident report.

**NEUROLOGICAL HISTORY:**

- Headache:**  frequent  left sided  right sided  whole head  involving neck  with nausea  light sensitivity  aura; date of last headache \_\_\_\_\_
- Dizziness:**  occasional  frequent  lying down  getting up  changing position
- Stroke:**  transient  permanent effects:  speech  walking  use of arm or hand  weakness; date of stroke \_\_\_\_\_
- Head Injury:**  with loss of consciousness  with skull fracture; When? \_\_\_\_\_
- Seizures:**  past  recent  on medications for
- Numbness or tingling:**  right hand  left hand  right arm  left arm  right leg  left leg  right foot  left foot  face  still present  carpal tunnel syndrome  Sciatica
- Hearing:** partial loss  loss requiring hearing aid(s)  ringing in ears
- Vision:**  require glasses or contacts  loss of vision in one eye  both eyes  double vision  eye surgery
- Muscle weakness or wasting:**  polio  other neurological disorder  diagnosis \_\_\_\_\_
- Mental:**  depression requiring medication  anxiety requiring medication  memory loss  confusion
- Inflammation involving brain or nervous system**  Meningitis

**MUSCULOSKELETAL:**

	Arthritis	Sprains	Fractures	Surgery	Pain	Dislocation	Trauma
<b>Neck</b>							
<b>Upper back</b>							
<b>Lower back</b>							
<b>Hips</b>							
<b>Hands</b>							
<b>Fingers</b>							
<b>Arms</b>							
<b>Shoulders</b>							
<b>Ribs</b>							
<b>Legs</b>							
<b>Knees</b>							
<b>Ankles</b>							
<b>Feet</b>							

**Arthritis:**  osteoarthritis  rheumatoid  gout  **Bursitis**  **Tendinitis**

- Spine:**  bulging discs  herniated disc  stenosis; what part of the spine? \_\_\_\_\_
- Radiological studies:**  X-rays  Cat Scan  MRI; of what part of body and when? \_\_\_\_\_
- Trauma:**  Falls:  frequent falls  recent fall  past history of falls with injury (broken bones, torn tissues)
- Sports injuries:**  fractures  dislocations  torn cartilage in knee  tennis elbow
- Motor vehicle injury:** dates \_\_\_\_\_

**NOTES:**

**CURRENT MUSCULOSKELETAL COMPLAINT:**

	<b>Pain</b>	<b>Restriction</b>	<b>Numbness</b>	<b>Spasms</b>
Neck	_____	_____	_____	_____
Upper back	_____	_____	_____	_____
Lower back	_____	_____	_____	_____
Right hip	_____	_____	_____	_____
Left hip	_____	_____	_____	_____
Right shoulder	_____	_____	_____	_____
Left shoulder	_____	_____	_____	_____
Right elbow	_____	_____	_____	_____
Left elbow	_____	_____	_____	_____
Right hand	_____	_____	_____	_____
Left hand	_____	_____	_____	_____
Right thigh	_____	_____	_____	_____
Left thigh	_____	_____	_____	_____
Right knee	_____	_____	_____	_____
Left Knee	_____	_____	_____	_____
Right foot	_____	_____	_____	_____
Left foot	_____	_____	_____	_____
Other (explain) _____				

**On the following scale draw a line that represents the intensity of your pain at your worst site.**

Pain on your worst day or worst time of day:

Hardly there \_\_\_\_\_ Unbearable

Pain on your best day or best time of day:

Hardly there \_\_\_\_\_ Unbearable

Does the pain, spasm, numbness, and/or restriction affect your  sleep?  interactions with others?  
 ability to work?  activities of daily living? \_\_\_\_\_

**GENERAL MEDICAL HISTORY:**

**Allergies:**

To Medications (include type of reaction): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pollen  food \_\_\_\_\_

**Medication intolerances:** \_\_\_\_\_

**Nose:**  rhinitis  nasal allergies  sinusitis

**Mouth:**  uncorrected tooth decay  dentures  problems swallowing

**Thyroid:**  hyperthyroid  hypothyroid (low thyroid)  Hashimoto's thyroiditis  thyroid cancer

**Diabetes:**  Insulin  Pills  Eyes  circulation  neuropathy; Years since onset \_\_\_\_\_

**Other Endocrine Disorders:** \_\_\_\_\_

**Lungs:**  asthma  bronchitis  pneumonia  shortness of breath  emphysema  have to sit up at night to breath  lung cancer  lung surgery \_\_\_\_\_

**Heart:**  high blood pressure  chest pain or pressure  angina  heart attack  heart disease  
 high cholesterol  open heart surgery  angioplasty  irregular heart rate (atrial fibrillation)  
 racing heart (tachycardia)  slow heart rate (bradycardia)  congestive heart failure  
 carotid artery disease  carotid surgery  artery disease legs  varicose veins  edema (swelling in legs or feet)  vascular surgery

**Abdomen:**  indigestion  heart burn  esophageal reflux  difficulty swallowing  gastric ulcers  
 duodenal ulcers  gall stones  liver disease  hepatitis  jaundice  pancreatitis  frequent or chronic diarrhea  Crohn's disease  frequent or chronic constipation  colitis  hemorrhoids  colon cancer  
 gall bladder surgery  appendectomy  other abdominal surgery \_\_\_\_\_

**Urinary:**  frequent bladder infections  dropped bladder  cystitis  kidney disease  kidney infections  
 renal insufficiency or kidney failure  cancer of kidney  cancer of bladder

**Genital:** number of pregnancies \_\_\_ number of children \_\_\_  abnormal menses  menopause  
 pain with intercourse  cancer of cervix, uterus or ovaries  hysterectomy  tubes tied  
 surgical removal of ovaries  breast cancer  breast augmentation  surgery to breast

**Genital:**  enlarged prostate  erectile dysfunction  prostate cancer  vasectomy  prostate surgery

**Skin:**  eczema  skin itching  psoriasis  un-healing sores  persistent rash  eczema  
 skin cancer  basil cell  squamous cel l  melanoma  skin surgery \_\_\_\_\_

**Bone Loss:**  osteopenia  osteoporosis  last bone density scan \_\_\_\_\_

**Other Cancers Not Mentioned Above:** \_\_\_\_\_

**Surgery**  radiation treatment  chemotherapy; date of last bone scan \_\_\_\_\_

**Other surgeries not mentioned above (include year of surgery):**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CURRENT MEDICATIONS (include dose and how often you take them)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_