

Medical History

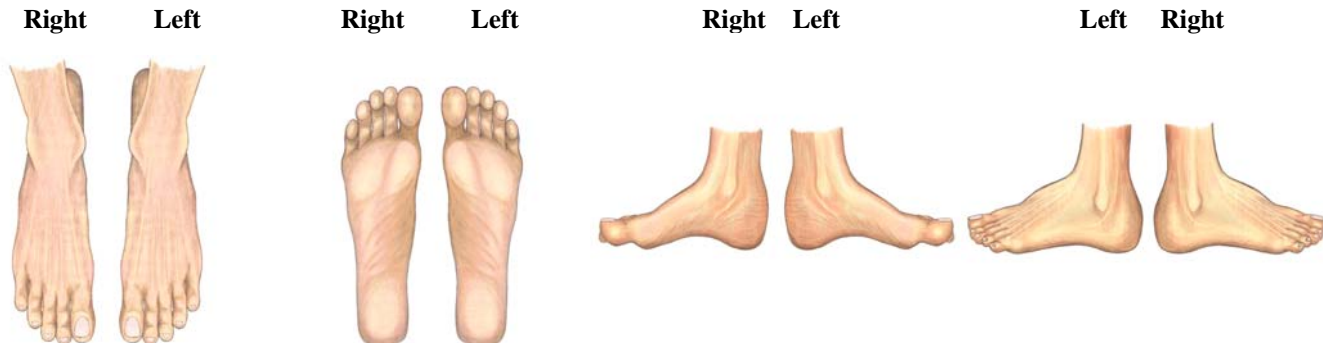
Patient Name: _____
 Date of Birth: _____

Primary Care Physician: _____
 Date Last Seen by PCP: _____
 Pharmacy Name/Phone: _____

Reason for Today's Visit: *(please check all that apply)*

Pain Swelling Numbness Deformity Other: _____

Please circle the area of concern:



How long have you had this problem: _____ Injury: No Yes (If yes, please complete back of form.)

Symptoms are: Improving Worsening Unchanged

Describe your pain: Sharp Dull Aching Burning Tingling Other: _____

Symptoms are worse when: Standing Walking Running Other: _____

Symptoms are worse: Morning Evening Night All Day

Previous treatments include: Rest Elevation Ice/heat Shoe Inserts Injections Brace/Bandage
 Surgery Medications Other: _____

Have you been previously treated for this condition by another physician: Yes No

Allergies: *(please list)*

Medications: *(please list. Use back of sheet if necessary)*

Name of Medicine	Dosage	What is it for?

Have you ever been treated for any of the following? *(Please check below)*

- | | | | | | |
|------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|----------------------------------|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stomach | <input type="checkbox"/> Circulation | <input type="checkbox"/> Nerves | <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Tumors | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Circulation | <input type="checkbox"/> Kidney | <input type="checkbox"/> Bladder | <input type="checkbox"/> HIV + | <input type="checkbox"/> Mental Disease |

Surgeries/Hospitalizations: *(Please list)*

Type (circle one)	Year	Surgery Name or Reason for Hospitalization
Surgery / Hospitalization		
Surgery / Hospitalization		
Surgery / Hospitalization		

Social History:

Height: _____ Weight: _____ Shoe Size: _____
 Pregnant: Yes No Claustrophobic: Yes No Metal in Body: Yes No Welder: Yes No
 Do you Smoke: Yes No Packs per day?: _____ How many years?: _____
 Do you drink Alcohol: Yes No How much?: _____

Medical History

Additional Medications:

Name of Medicine

Dosage

What is it for?

Injury Report:

Date of Injury: _____

How did injury occur?: (Please be as detailed as possible)

If Work Comp Related:

Employer Name: _____

Employer Phone: _____

Employer Address: _____

Administrator Name: _____

Name of Carrier: _____

Name of Adjuster: _____

Carrier Phone: _____

Carrier Address: _____

Claim Number: _____

If Auto Related:

Insurance Co Name: _____

Insurance Co Phone: _____

Contact Name: _____

Insurance Co Address: _____

Claim Number: _____