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PATIENT HISTORY FORM

Date: _______/_________/________

NAME: ____ Birthdate: _____/______/_____
Last First M. I.

Age:___________ Sex: ❑ F ❑ M

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

Whom do we thank for referring you here? ____

Name of your primary care physician: ____

Describe briefly your present symptoms: ____________

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:

Left Right Left

Left Right

Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

When did your symptoms start? ____________

What diagnosis have you been given, if any?

Please list the names of other practitioners you have seen for this problem: ____________

Previous treatment for this problem (include physical therapy, surgery, and injections; medications to be listed later):

Sleeping Position- ❑ Back ❑ Side ❑ Stomach ❑ Other, please explain:

What type of pillow do you use?
❑ Traditional ❑ Cervical ❑ None ❑ Other, please explain:

How many pillows do you sleep on? ❑ One ❑ Two ❑ None ❑ Other, please explain

ARTHRITIS HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

	Yourself	Relative	→	Name/relationship
Arthritis (type unknown)	❑	❑	→	____________
Osteoarthritis	❑	❑	→	____________
Rheumatoid arthritis	❑	❑	→	____________
Gout	❑	❑	→	____________
Lupus or "SLE"	❑	❑	→	____________
Ankylosing spondylitis	❑	❑	→	____________
Osteoporosis	❑	❑	→	____________
Psoriasis/psoriatic arthritis	❑	❑	→	____________

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Hypothyroidism
❑ Goiter
❑ Cancer (type) ____________
❑ Leukemia
❑ Psoriasis
❑ Angina
❑ Heart problems

❑ Heart murmur
❑ Pneumonia
❑ Pulmonary embolism
❑ Asthma
❑ Emphysema
❑ Stroke
❑ Epilepsy (seizures)
❑ Cataracts
❑ Kidney disease
❑ Kidney stones

❑ Crohn's disease
❑ Colitis
❑ Anemia
❑ Jaundice
❑ Hepatitis
❑ Stomach or peptic ulcer
❑ Rheumatic fever
❑ Tuberculosis
❑ HIV/AIDS
❑ Pacemaker

Other significant illnesses (please list): ____________________________

Previous Operations/ Hospitalizations

Type	*Year*	*Reason*
1. ____________	______	____________
2. ____________	______	____________
3. ____________	______	____________
4. ____________	______	____________
5. ____________	______	____________
6. ____________	______	____________
7. ____________	______	____________

Any previous fractures? ❑ No ❑ Yes Describe ____________________

Any other serious injuries? ❑ No ❑ Yes Describe ____________________

Do you smoke? ❑ Yes ❑ No ❑ In the past - How long ago? ________

Do you drink alcohol? ❑ No ❑ Yes : Usual drink: ________ How much: ____________

Has anyone ever told you to cut down on your drinking? ❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ No ❑ Yes If yes, please list: ____________

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

Do you have a pacemaker? ❑ Yes ❑ No

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? ______________________________

____

Please list any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

Name of drug	Dose (include strength and number of pills per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

PERSONAL HISTORY

What is your highest educational level? ❑ High school ❑ Some college courses ❑ College graduate ❑ Advanced degree

What is your current or past occupation? ______________________________

Are you currently working? : ❑ Yes ❑ No If yes, hours/week _______ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability?______________________________

What date did this disability begin? _____________

With whom do you currently live? ______________________________

How much exercise do you get each week? ____________________ What kind of exercise? __________________

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at death	Cause
Father				
Mother				

Number of siblings: ________ Number living _________

Number of children ________ Number living _________ List ages of each ________________________

Health of children: ______________________________

____

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SYSTEMS REVIEW

Date of last eye exam ________ Date of last chest x-ray ________

Date of last bone density test ____________

Result of last TB (PPD) test: ❑ Never done ❑ Negative ❑ Positive Date test performed: ___________

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Morning stiffness
  Lasting how long ____ Minutes
  ____ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

List joints affected in the last 6 months

____

____

____

____

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye

MOUTH
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑Loss of taste
- ❑ Dryness
- ❑ Recent increase in tooth cavities

NOSE
- ❑ Nosebleeds
- ❑ Loss of smell

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw while chewing

NECK
- ❑ Swollen glands
- ❑ Tender glands

HEART AND LUNGS
- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain relieved by food
- ❑ Vomiting of blood/"coffee grounds"
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

KIDNEY/URINE/BLADDER
- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, "smoky" urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Frequent urination
- ❑ Getting up at night to pass urine
- ❑ Prostate trouble

BLOOD
- ❑ Anemia
- ❑ Bleeding tendency

SKIN
- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive
- ❑ Skin tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold (Raynaud's)

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling in hands/feet
- ❑ Memory loss
- ❑ Muscle weakness

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

HABITS

☐Smoke: Packs Daily____________ How Long_________ Interested in Stopping No Yes
☐Coffee: Cups Daily ____________ Other Caffeine __________________________
☐Alcohol: Type _________________ Amount _______________________________
☐Sleep:
How many hours at night_____

Difficulty falling asleep	No	Yes
Difficulty staying asleep	No	Yes
Snoring	No	Yes
Early morning awakening	No	Yes
Daytime drowsiness	No	Yes

☐Exercise routine:
____
☐Diet: Salt intake _____________ Fat Intake_____________________

I have completed these questions to the best of my ability and understand that this information is needed in order to help my provider provide the best possible medical care for me:

Patient Signature: ____________________________________ Date: ______________________________

Reviewed by: _______________________________________ Date: ______________________________