INJURY AND HEALTH INSTITUTE

Patient History Form

Patient's Name:_____
(Last Name) (Fist Name) (M.I.)

Date of Birth:_____ O Male O Female Height:_____ Weight:_____

Primary Care Physician Name:_____ Phone Number:_____
Primary Physician name:_____ Phone Number:_____

Visit Type:

O Personal Injury O Work Injury O Second Opinion O Independent Medical Exam (IME)

O Consultation O Other_____

Chief Complaint:

What part of your body/location is your pain coming from?

O Neck Pain(Cervical) O Mid Back Pain (Thoracic) O Lower Back (Lumbar)

O Other_____

Do you have a prior history of this pain/injury? O NO O YES, Please describe:_____

Was this problem: O Sudden, since _____ O Gradual, since_____ O or Following an injury, since_____
(Date) (Date) (Date)

Is this a on the job injury/ Worker's Compensation Injury? O NO O YES Date of injury:_____

Have you had any prior treatment for this problem/injury? O NO O YES

If YES, describe what has helped and not helped with you pain/injury._____
_____
_____

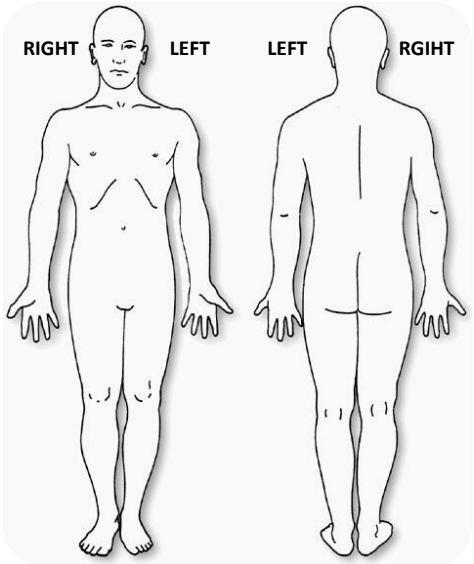
Please give a brief description on how you were injured/ reason for you visit:_____
_____
_____

Please check/ describe the type of pain you have: O Stabbing O Burning O Pains/Needles O Deep Achy O Numbing

O Other,_____

Use the body char and draw using the provided symbols to show where your pain is and how it feels:
(Use as many symbols that apply)

= Severe Pain Z = Moderate Pain = Shooting Pain /// = Numbness



Pain Severity Scale

On a Scale from 1-10 please circle your **OVERALL** pain level?

1 2 3 4 5 6 7 8 9 10

mild **intolerable**

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ALLERGIES/ ADVERSE REACTIONS:

Allergy to medications: O NO O YES, Please check or list all medications you are allergic to and the reactions you have:

O Penicillin	O Ibuprofen	O Iodine
O Sulfa	O Acetaminophen	O Morphine
O Aspirin	O Erythromycin	O Latex
O Codeine	O Tetracycline	O Local Anesthetic

Other Medications Allergies: _____
_____

Food Allergies: O NO O YES, Please indicate below:

Please Specify: _____
_____

PRESENT MEICATION & DOSAGE:

Please list below all the current medications & supplements you are taking or have taken in the last month.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Current Pharmacy: _____ **PHARMACY PHONE #**: _____

PAST MEDICAL HISTORY:

Please check all medical conditions that apply. If none of the medical conditions below apply to you, check here: O

○ Alcoholism	○ Gynecological Problems	○ Migraines
○ Anemia	○ Headaches	○ Muscular Disorder
○ Angina	○ Heart Attack	○ Obesity
○ Arthritis	○ Heart Disease	○ Orthopedic Problems
○ Asthma	○ Hepatitis	○ Prostate Problems
○ Bleeding Disorders	○ Hiatal Hernia	○ Pulmonary Embolism
○ Cancer	○ High Blood Pressure	○ Reaction to Anesthetic
○ Chemical Dependency	○ High Cholesterol	○ Respiratory Infections
○ Claustrophobia	○ HIV or AIDS	○ Scoliosis
○ Congestive Heart Failure	○ Irregular Heart Rhythm	○ Seizures/ Epilepsy
○ COPD	○ Kidney Disease	○ Sleep Apnea
○ Depression	○ Loss of ladder Control	○ Stroke
○ Diabetes	○ Loss of Bowel Control	○ Thyroid Disorders
○ Fibromyalgia	○ Liver Disease	○ Ulcer
○ Gastrointestinal Disease	○ Lung Disease	○ Urinary Problems
○ Glaucoma	○ Lupus	○ Urinary Problems
○ Gout	○ Malignant Hyperthermia	

Other Medical Conditions: _____
_____
_____

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SURGICAL HISTORY:

Please list all past surgical procedures. If you had no previous surgeries or procedure check here: O

____ ____
____ ____
____ ____
____ ____
____ ____

FAMILY HISTORY:

Does anyone in you immediate family (blood relatives: mother, father, son, daughter etc.) have or had any of the following :

Family Member: ______________________________ O Living O Deceased & at what age ____________________

O Alcoholism O Cancer O Diabetes O High Blood Pressure O Heart Disease O Depression O Vascular Disease

Other:____

Family Member: ______________________________ O Living O Deceased & at what age ____________________

O Alcoholism O Cancer O Diabetes O High Blood Pressure O Heart Disease O Depression O Vascular Disease

Other:____

Family Member: ______________________________ O Living O Deceased & at what age ____________________

O Alcoholism O Cancer O Diabetes O High Blood Pressure O Heart Disease O Depression O Vascular Disease

Other:____

Family Member: ______________________________ O Living O Deceased & at what age ____________________

O Alcoholism O Cancer O Diabetes O High Blood Pressure O Heart Disease O Depression O Vascular Disease

Other:____

SOCIAL & OCCUPATIONAL HISTORY:

Marital Status: O Married O Single O Divorced O Separated O Widowed O Domestic Partner

Number of Children: _____________ **FEMALES:** is the **ANY** chance you could be pregnant? O YES O NO_________________

(Patient Initials)

Current Occupation/ Position: ____

Your Current Work Status: O Full Time O Part Time O Unemployed O Retired O Disabled O Medical Leave

Your current Employer's Name: ______________________________________

What are your Interests/ Hobbies ______________________________________

Have you been a prior smoker: O YES O NO Date Quit: ________________________

Do you currently smoke NOW?: O YES O NO If yes, then how frequently: __________ packs per day/week for ______________ years

Do you drink alcoholic beverages> O YES O NO

OTHER PATIETN HISTORY:

If there is anything in your health history you would like to relay that is not already specified, please describe it in the spaces below:

____
____
____
____