Patient Name _____ **Past Medical History** Date_____

Please check any condition you have or have had. ☐No medical history to report

☐Allergies
☐Anemia
☐Anxiety
☐Arthritis
☐Asthma
☐Blood transfusion
☐Cancer
☐Congestive Heart Failure
☐Nerve/Muscle Disease
☐Lung disease
☐Meningitis
☐Depression
☐HIV/AIDS
☐Kidney Disease
☐Diabetes mellitus
☐Clotting Disorder (blood clot)
☐High Blood Pressure
☐Acid Reflux
☐Glaucoma
☐Gout
☐Heart Attack
☐High Cholesterol
☐Osteoporosis
☐Seizures
☐Sickle Cell Anemia
☐Stroke
☐Substance Abuse
☐Thyroid disease
☐Tuberculosis
☐Ulcers
☐Anesthetic Complications
☐Cataracts
☐Other:_____

Past Surgical History

Please check any surgery you have had. ☐Never had surgery

☐Appendix
☐Brain Surgery
☐Breast Surgery
☐Open Heart or Bypass Surgery
☐Gall Bladder
☐Colon Surgery
☐Fracture Surgery
☐Hernia Repair
☐C-Section
☐Eye Surgery
☐Hysterectomy
☐Joint Replacement
☐Small Intestine Surgery
☐Spine Surgery
☐Tubes Tied
☐Heart Valve Replacement
☐Cosmetic Surgery
☐Orthopaedic Surgery _____
☐Other:_____

Social History

Please check all that apply

☐Current Every Day Smoker
☐Current Some Day Smoker
☐Former Smoker
Quite Date _____
☐Never Smoker
☐Passive Smoker (2nd Hand Smoke)
☐Vaping
☐Alcohol: Drinks/week
_____ Glasses of wine
_____ Cans of Beer
_____ Shots of Liquor
_____ Drinks containing 0.5oz of alcohol
☐ Drug use: Uses/week _____
☐Marijuana
☐Cocaine
☐Methamphetamines
☐IV

Family Medical History

Please write in any medical condition or disease that has been in your family

Disease	Family Member(s)		Disease	Family Member(s)

Current Medications ☐No medications

Medication	Strength	How Often?

Medication Allergies ☐No known medication allergies

Medication	Reaction		Medication	Reaction

Primary Care Provider: _____ Pharmacy: _____

Current Problem

Name: _____ Age:_____ Right Handed / Left Handed / Ambidextrous / Cross-dominant

Reason for today's visit: _____

Date of onset of symptoms: _____ Is this visit due to Injury or Accident? Yes / No If yes, did it happen at work? Yes / No

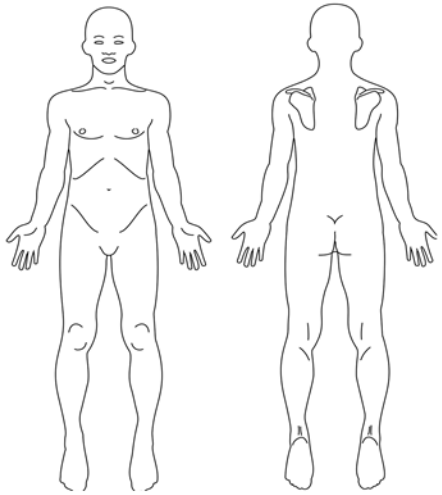
Please describe what happened: _____

Since onset the symptoms are: Improving / Worsening / Staying the same

Pain is: Sharp / Dull / Achy / Throbbing

Indicate where your pain is located on the diagram below.

Do not indicate areas of pain that are not related to your current problem



Pain Rating: On a scale of 0-10

0= No Pain 10= Worst pain imaginable

At best: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

At worst: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

What makes your pain better? _____

What makes your pain worse? _____

Does your pain wake you up at night? Y / N

Do you experience any ☐ clicking ☐ popping ☐ locking ☐ crunching

Do you experience any numbness/tingling in the effected extremity? Y / N

How far can you walk? _____ What stops you? _____

Have you been treated previously for this injury? Y / N Where? _____ Surgery on this extremity? Y / N If yes, describe _____

Non-surgical: ☐ Physical Therapy (How long? _____) ☐ Corticosteroid Injection (how many? _____) ☐ Spling/Brace ☐ Other _____

What pain medications are you taking for this problem? ☐Anti-inflammatory (Ibuprofen/Motrin/Advil) ☐Acetaminophen (Tylenol) ☐Other _____

Prior Diagnostic tests: ☐ EMG ☐ X-rays ☐ CT Scan ☐ MRI ☐Other Diagnostic Tests: _____

What activities is this injury preventing you from doing? _____

What do you do for work? _____ Do you smoke? Y / N Amount_____