PAST MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

Social Security Number: _____ email address: _____

Are you presently working? ☐ Yes ☐ No Who is your employer? _____

Date of next physician visit: _____ _____

Date of injury / onset: ____/____/____ Have you ever had these symptoms before? ☐ Yes ☐ No

How did you symptoms start:

_____

Please check all that apply to your symptoms:

☐ Work related injury ☐ Recurrence of previous injury
☐ Motor vehicle accident ☐ Injury related to lifting ☐ Injury related to falling
☐ Cause unknown ☐ Athletic / recreational injury ☐ Other: _____

Have you had a related surgery? ☐ Yes ☐ No

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
Chest Pain / Angina	☐	☐	Allergies to Heat	☐	☐
High Blood Pressure	☐	☐	Allergies / Poor tolerance to Cold	☐	☐
Heart Disease	☐	☐	Other Allergies	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heart Palpitations	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐
Headaches	☐	☐	Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fractures	☐	☐
Are you pregnant?	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	Sexual Dysfunction	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Nausea / Vomiting	☐	☐
Urine Leakage	☐	☐	Ringing in your ears	☐	☐
Asthma / Breathing Difficulties	☐	☐	Rheumatoid Arthritis	☐	☐
Liver / Gallbladder Problems	☐	☐	Special Diet Guidelines	☐	☐
Smoking	☐	☐	Hypoglycemia	☐	☐
Stroke/CVA	☐	☐	History of MRSA colonization	☐	☐
			Other:_____		

If yes on any of the above, please briefly explain and give approximated date:

Is there any other information regarding your past medical history that we should know about?

Are you presently taking Medication? ☐ Yes ☐ No

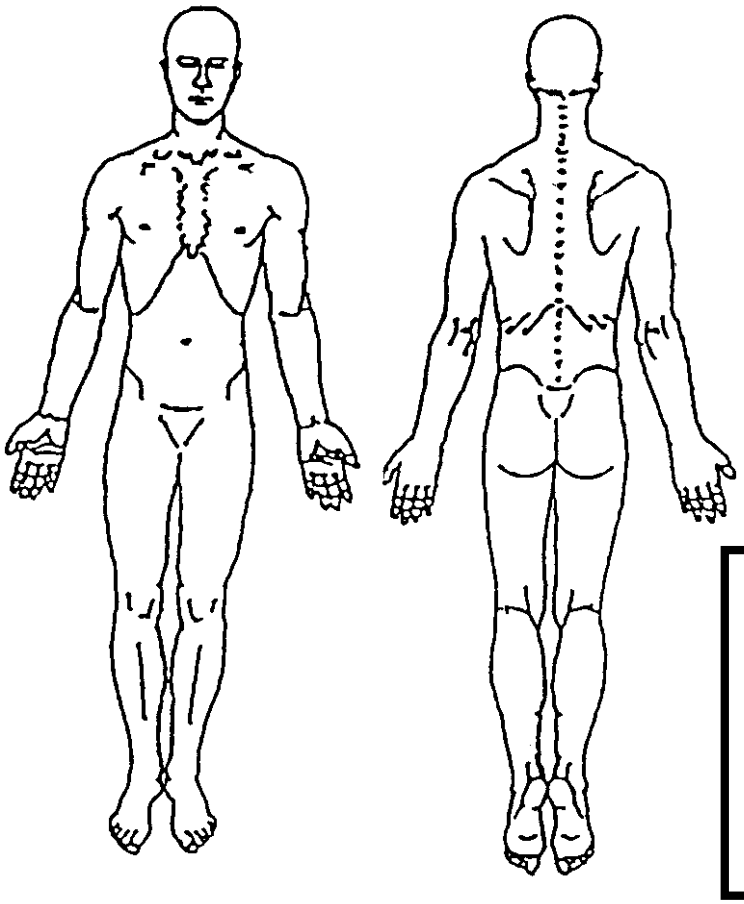
If yes, please list what medications and for what condition:

In the rare instance of an emergency, whom should we contact?

Name: _____

Phone Number: _____

Please indicate below where your symptoms are located.



KEY:

Numbness ========

Pins & Needles ooooooo

Burning Pain xxxxxxxx

Stabbing Pain / / / / / / / /

Average pain intensity: (circle one)

Last 24 hrs: no pain 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: : no pain 1 2 3 4 5 6 7 8 9 10 worst pain

How often do you experience symptoms? (circle one)

1. Constant (76-100% of the time) 2. Frequent (51-75% of the time) 3. Occasional (26-50%) 4. Intermittent (0-25%)

How much have your symptoms interfered with your usual daily activities (including both work outside home and housework) (Circle one)

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

In general would you say your overall health right now is: (circle one)

1. Excellent 2. Very good 3. Good 4. Fair 5. Poor

Patient's Signature _____ Date _____ Signature of Guardian if patient is a minor _____ Date _____