

Patient History/Problem List

Patient Name: _____

Date: _____

Date of Birth: ____ / ____ / _____

Physician: _____

Initial Eval: ____ / ____ / _____

Date of Next Physician Visit? ____ / ____ / _____

A. Personal Medical History:

1. Please Circle all conditions which you have or have had in the past:

Allergies

High blood pressure

Angina/chest pain

HIV positive

Arthritis

Hypoglycemia

Asthma/breathing disorders

Kidney disease

Back pain

Liver/gallbladder disease

Blood disorders

Lyme disease

Bowel/bladder disorder

Meningitis

Cancer _____

Multiple Sclerosis

Diabetes

Neuritis

Dizziness/fainting

Osteoporosis

Eating disorders

Pacemaker

Epilepsy/seizures

Parkinson's Disease

Fractures

Phlebitis

Head aches

Pregnant

Hearing difficulty

ringing in ears

Heart conditions/disease

Stroke

Hepatitis

Tuberculosis

Hernia

Other _____

2. Allergies (specify): _____

3. Medications: _____

4. Implants(metal/plastic): _____

5. Diagnostic tests/procedures: _____

6. Surgeries: _____

B. Present Medical History:

1. Date of injury/ start of symptoms: ____ / ____ / _____

2. Have you ever had these symptoms before? Y / N

3. Do you currently have pain? Y / N

4. How would you rate your pain? 0-1- 2 - 3 - 4- 5 -6-7 -8 - 9 -10

(0 = no pain 5 = moderate pain 10 = severe pain)

5. Does anything make your pain better?

6. Does anything make your pain worse?

7. Please indicate where your symptoms are located?

8. Circle which apply to your symptoms:

work related recurrence of previous injury

related to fall motor vehicle accident

athletic/recreational related to lifting

daily activities other: _____

9. Have you had a related surgery? Y / N

10. Are you presently employed/working? Y / N

11. Do you plan on returning to work? Y / N

Date

Signature

Relationship to patient