Patient History Form

Patient's Name_____ Gender: ☐ Male ☐ Female

Date of Birth:_____ Age:_____ Height_____(ft)_____(in) Weight _____(lbs)

Primary Care Physician/Pediatrician:_____

Referring Physician/Hospital:_____

Chief Complaint for Today's Visit

Reason for today's visit?_____

When did the problem first begin/or when was it first noticed?_____

How did it happen?_____

Has the patient been evaluated or treated by another physician? _____

If yes, what was the treatment/recommendation?_____

_____

Is there any pain? How bad is the pain 0-10 (10 being the worst)_____

Is the pain (circle one): getting better getting worse staying the same

Past Medical History (circle all that apply)

ADHD	Coronary Heart Disease	Radiation
Anxiety	Depression	Reflux Disorder
Arthritis	Diabetes	Schizophrenia
Artificial Joints	Hearing Loss	Seizures
Asthma	Hepatitis	Sleep Apnea
Bipolar Disorder	HIV/AIDS	Stroke
Blood Marrow Transplantation	Hypercholesterolemia	Valve Replacement
Cancer_____	Hypertension	Other_____
Cerebral Palsy	Hyper/hypothyroidism	
COPD	Pacemaker	

List all current medications and dosages:

_____

_____

Does the patient have any allergies? If yes, please list all allergies and associated reaction:

_____

_____

Patient Name: _____

Past Surgical History: (please list types of surgery, area of body and age surgery occurred)

_____

_____

Orthopedic History: (please list all past orthopedic injuries or issues)

_____

_____

Family History:

(If any immediate relatives have ever had the following, please write their relation beside the disorder):

Cancer _____ Diabetes _____ Epilepsy _____

Heart Condition_____ Hypertension_____ Stroke_____

Sickle Cell_____ Mental Illness _____ Kidney Disease_____

Bleeding Disorder_____ Scoliosis_____ Other_____

Social History: (Circle all that apply)

Cigarette Smoking: Never Smoke Smoke Occasionally Quit Smoke Daily (how much)_____

Alcohol Use: Never Drink Drink Occasionally Drink Daily (how many)_____

Recreational Drugs: Never Use Use Occasionally Use Daily_____

If used please list drug(s):_____

How often do you exercise: _____ times a week Daily Never

Review of Systems: (Check all that apply)

___ joint pain ___ joint swelling ___ joint stiffness

___ unsteady gait ___ numbness ___ tingling

___ dizziness ___ headaches ___ tremors

___ fatigue ___ unexpected weight loss ___ fever

___ chills ___ weight gain ___ poor healing wounds

___redness ___ rash ___itching

___ scarring/keloids ___ easy bleeding ___ easy bruising

___ enlarged lymph nodes ___ allergic reaction to foods/environment ___ chest pain

___ palpitations ___ fainting ___ heart murmur

___ leg cramps
___ excessive thirst and urination
___ corrective lenses
___ blurred vision
___ heartburn
___ nausea/vomiting
___ constipation
___ diarrhea
___bloody/tarry stools
___ frequent urination
___ difficult/painful urination
___ incontinence
___ blood in urine
___ shortness of breath
___ wheezing
___ cough
___ hurts to breath
___ anxiety
___ depression
___ nervousness
___ hallucinations
___ immunosuppression

Child's Birth History (for patients under 18 years of age)

Birth Place (hospital)_____ City_____ State_____

Birth Weight_____lbs. _____oz. Premature ☐ No ☐ Yes, _____weeks early

Breech position? ☐ No ☐ Yes Cesarean Section? ☐ No ☐ Yes, reason_____

Any complications/concerns at birth?_____

For mother: # of pregnancies:_____ # of children:_____ Order of this child:_____

Any problems with pregnancy?_____

Developmental History

Child sat up at age_____ Child walked at age_____ Child spoke at age_____

Education and Home Life

What school does the child attend? _____

What grade level is the child currently in?_____

Whom does the child live with?_____

Signature of person completing form:_____

Relationship to patient, if not self:_____ Date:_____