



# PATIENT HISTORY

Patient Name \_\_\_\_\_ Age \_\_\_\_\_

Your Primary Care Physician \_\_\_\_\_

Who referred you to our Clinic? \_\_\_\_\_

What are we seeing you for today? \_\_\_\_\_

Left or Right (Circle one)

Date of injury \_\_\_\_\_ Did this injury occur at work? \_\_\_\_\_  
\_\_\_\_\_ Sports \_\_\_\_\_ Other \_\_\_\_\_

How did your injury occur? \_\_\_\_\_

## Past medical History (if yes, explain below:)

YES	NO	Hypertension	YES	NO	Diabetes	YES	NO	Dentures
YES	NO	Neurologic Disease	YES	NO	Bleeding	YES	NO	Contact Lens
YES	NO	Heart Disease	YES	NO	GI Disease	YES	NO	Cough
YES	NO	Liver Disease	YES	NO	Alcohol	YES	NO	Smoke
YES	NO	Lung Disease	YES	NO	Drugs	YES	NO	Mot. Sickness
YES	NO	Kidney Disease	YES	NO	Steroids	YES	NO	Other

Explanation: \_\_\_\_\_

Current for (circle if applicable) HEPATITIS B VACCINATION, TETANUS OR FLU VACCINE, CHILDHOOD IMMUNIZATIONS

Pharmacy Name/Phone #: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Past Injuries: \_\_\_\_\_

Past Surgeries/Dates: \_\_\_\_\_

Have you had ANY previous testing or studies done regarding the problem that you are here for today? (MRI, Arthrogram, X-rays, CT Scan, etc.) \_\_\_\_\_

If so, what test? \_\_\_\_\_

Where: \_\_\_\_\_ When? \_\_\_\_\_

Ordered by Dr. \_\_\_\_\_