Patient History

Patient Name: _____ Today's Date: _____

Age:_____ ☐ Male ☐ Female Date of Birth: _____

Height:_____ ☐ Right Handed Date of Injury:_____

Weight: _____ ☐ Left Handed

Family Doctor:_____ Referring Doctor: _____

Reason for today's appointment: _____

Symptoms you have:_____

Have you had any recent x-rays of this area? ☐ Yes ☐ No

If yes, when and where: _____

Medical History: (Circle all that apply)

Anemia	Cancer	Heart Problems	Lung Problems
Stroke	Broken Bones	Diabetes	Hypertension
Pacemaker	Thyroid	Other_____	

Surgical History: (List prior surgeries and dates)

_____ _____ _____

_____ _____ _____

Current Medications:

Name	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to medications: _____

Social History:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Never ☐ Previously, but quit ☐ Current / packs per day _____

Alcohol Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Family History:

Arthritis	Diabetes	Heart Disease	Other _____
Cancer	Lung Disease	Hypertension	

Physician Reviewed:_____ Date: _____