

PATIENT HISTORY FORM *(Please Print)*

Patient Name: _____ Age: _____ Date of Birth: _____

VISIT INFORMATION

Chief Complaint: _____ Body Part: _____ Date Started: _____

Describe How Problem Started and its Course: _____

Doctor or person who referred you for this problem: _____

Have you been treated for this problem? Yes No If yes, by whom? _____

Occupation: _____ Right handed Left handed

Duties: _____

TREATMENT you have had done for this problem *(X-rays, MRI's, CT Scans, Bone Scans, EMG's, EKG's, Injections, Medications, Therapy, and so forth)*

Name of Test	Body Part Tested	Date of Test	Where Was Test Done?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

VITAL SIGNS *(to be completed by Office Staff only)*

BP: _____ Temp: _____

Pulse: _____ Weight: _____

Resp: _____ Height: _____

Tobacco Use

Do you smoke? Yes No How many packs daily? _____ How many years? _____ When stopped? _____

Alcohol Use

Do you drink alcohol? Yes No Less than 1 drink daily 1-2 drinks daily 3 or more daily

ALLERGIES

Are you allergic to any drugs, medications, latex, nickel, etc? Yes No

List Allergy

List Reaction(s) *(example: hives, skin rash, itching, shock, shortness of breath, fever, etc.)*

- | | |
|----------|-------|
| 1) _____ | _____ |
| 2) _____ | _____ |
| 3) _____ | _____ |
| 4) _____ | _____ |
| 5) _____ | _____ |

Patient Name: _____ Age: _____ Date of Birth: _____

MEDICATIONS (THIS SECTION MUST BE COMPLETED)

List all prescription drugs, over the counter medicines, herbal remedies, inhalers, birth control pills, diet pills, blood thinners (Coumadin, Warfarin, Lovenox, Plavix, Aspirin, etc.) you are currently taking.

<u>Name of Medication(s)</u>	<u>Dosage</u>	<u>Frequency of Usage</u>
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____
7) _____	_____	_____
8) _____	_____	_____
9) _____	_____	_____
10) _____	_____	_____

PHARMACY

Name of pharmacy you'd like us to use for medications: _____

Address: _____ Phone: _____

Bone, Joint, Muscle and Other Problems

Bone or Joint Infection Yes No Deep Vein Thrombosis Yes No Gout Yes No
 Bursitis Yes No Fractures Yes No Rheumatoid Arthritis Yes No
 Other _____

Surgical History

Ankle Fracture Surgery Yes No Humerus Fracture Surgery Yes No Other: _____
 Arthroscopic Knee Surgery Yes No Knee Replacement Yes No _____
 Arthroscopic Shoulder Surgery Yes No Laminectomy Yes No _____
 Carpal Tunnel Release Yes No Shoulder Replacement Yes No _____
 Elbow Fracture Surgery Yes No Spinal Fusion Yes No _____
 Femur Fracture Surgery Yes No Wrist Fracture Surgery Yes No _____
 Hip Replacement Yes No _____

Medical History

Anemia Yes No Depression Yes No Osteoporosis Yes No
 Arrhythmia Yes No Diabetes Mellitus Yes No Peripheral Arterial Disease Yes No
 Arthritis Yes No Gout Yes No Prostate Cancer Yes No
 Asthma Yes No Hepatitis Yes No Psoriasis Yes No
 Bleeding Disorder Yes No HIV/AIDS Yes No Stomach Ulcer Yes No
 Blood Clots Yes No Hyperlipidemia Yes No Stroke Yes No
 Cancer Yes No Hypertension Yes No Thyroid Disease Yes No
 COPD Yes No Liver Disease Yes No Restricted Diet: _____
 Coronary Artery Disease Yes No Metal Allergy Yes No Other Medical History: _____
 MRSA Yes No _____

YOU MUST PRINT THIS FORM OUT AND BRING IT WITH YOU TO YOUR APPOINTMENT.
 THIS FORM DOES NOT AUTOMATICALLY GET SENT TO ASPEN.
 IF YOU DO NOT PRINT THIS FORM OUT, THE INFORMATION WILL BE LOST.