

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 Shoe Size _____

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

Current smoker? Yes No How many packs daily? _____ How many years? _____
Former smoker? Yes No Quit date? _____ Smokeless tobacco? Current user Former user Never used

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, jewelry, 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 (ex: Naproxen, Mobic, Meloxicam, Celebrex, etc.), over the counter medicines (ex: Ibuprofen, Aleve, etc.), herbal remedies, inhalers, birth control pills, diet pills, blood thinners (ex: 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 Shoulder/Humerus Fracture Surgery Yes No Other: _____

Arthroscopic Knee Surgery Yes No Knee Replacement Yes No _____

Arthroscopic Shoulder Surgery Yes No Laminectomy/Spine Surgery Yes No _____

Carpal Tunnel Release Yes No Shoulder Replacement Yes No _____

Elbow Fracture Surgery Yes No Spinal Fusion Yes No _____

Thigh/Femur Fracture Surgery Yes No Wrist Fracture Surgery Yes No _____

Hip Replacement Yes No _____

Medical History

Anemia/Low Blood Count Yes No Depression Yes No Osteoporosis/Brittle Bones Yes No

Arrhythmia/Irregular Heartbeat Yes No Diabetes Mellitus Yes No Peripheral Arterial Disease/Poor Circulation Yes No

Arthritis Yes No Hepatitis Yes No Psoriasis/Skin Rashes Yes No

Asthma Yes No HIV/AIDS Yes No Stomach Ulcer/Heartburn/Reflux Yes No

Bleeding Disorder Yes No Hyperlipidemia/High Cholesterol Yes No Stroke Yes No

Blood Clots Yes No Hypertension/High Blood Pressure Yes No Thyroid Disease Yes No

Cancer Yes No Liver Disease Yes No Restricted Diet: _____

COPD Yes No Metal Allergy/Rash from Jewelry Yes No Other Medical History: _____

Coronary Artery Disease Yes No MRSA/Resistant Staph Infection 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.