

**PATIENT MEDICAL/SOCIAL HISTORY**

Age: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Patient Name \_\_\_\_\_  single  married  divorced  widowed # of children \_\_\_\_\_

Family Doctor: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred By:      Family Doctor      Other Doctor / ER / Urgent Care \*\*list below      Family/Friend      Self      Other

NAME \_\_\_\_\_ FACILITY NAME \_\_\_\_\_ CITY \_\_\_\_\_ PHONE \_\_\_\_\_

Body part to be evaluated, including left or right \_\_\_\_\_ Have x-rays been taken?  Yes  No

Symptoms (for example: pain, popping, numbness, etc.) \_\_\_\_\_

Was this caused by an injury?  No  Yes  
If yes, complete the following:

Who are we billing for these services?  
 Workers Compensation (complete questionnaire)

How \_\_\_\_\_

Auto Insurance (complete liability questionnaire)

When/Date \_\_\_\_\_

Third Party/Liability (complete liability questionnaire)

Where \_\_\_\_\_

Private Insurance

Do You Smoke?  Yes  No How Much \_\_\_\_\_ Do You Drink Alcohol?  Yes  No How Much \_\_\_\_\_  
Females (for x-ray):  pregnant  possibly pregnant

What is your job and briefly describe your physical duties: \_\_\_\_\_

Have you had any of the following surgeries/operations/complications? Please list the year it was done.

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Abdomen                | <input type="checkbox"/> Cholecystectomy                          | <input type="checkbox"/> Lumpectomy/Mastectomy                  | <input type="checkbox"/> Post-Op vomiting            |
| <input type="checkbox"/> Amputation             | <input type="checkbox"/> Coronary Angioplasty/Stent               | <input type="checkbox"/> Pacemaker                              | <input type="checkbox"/> Other Post-Op complications |
| <input type="checkbox"/> Appendectomy           | <input type="checkbox"/> Gastric Bypass                           | <input type="checkbox"/> Parathyroidectomy                      | <input type="checkbox"/> Other _____                 |
| <input type="checkbox"/> Arterial Bypass        | <input type="checkbox"/> Total Hip Replacement (right/left/both)  | <input type="checkbox"/> Prostatectomy                          |  |
| <input type="checkbox"/> Back                   | <input type="checkbox"/> Hip Hemiarthroplasty (right/left/both)   | <input type="checkbox"/> Rotator Cuff Repair (right/left/both)  |  |
| <input type="checkbox"/> Breast                 | <input type="checkbox"/> Hysterectomy                             | <input type="checkbox"/> Shoulder Arthroscopy (right/left/both) |  |
| <input type="checkbox"/> CABG                   | <input type="checkbox"/> Interventional pain procedures           | <input type="checkbox"/> Tonsillectomy                          |  |
| <input type="checkbox"/> Carotid Endarterectomy | <input type="checkbox"/> Knee ACL Repair (right/left/both)        | <input type="checkbox"/> Valve Replacement                      |  |
| <input type="checkbox"/> Carpal Tunnel          | <input type="checkbox"/> Total Knee Replacement (right/left/both) | <input type="checkbox"/> Problems with bleeding or anesthetics  |  |
| <input type="checkbox"/> Cataract Extraction    | <input type="checkbox"/> Knee Arthroscopy (right/left/both)       | <input type="checkbox"/> Post-Op delirium                       |  |

Have you been diagnosed with any of the following illnesses?

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Urinary Tract Infection (Chronic) |
| <input type="checkbox"/> Angina                    | <input type="checkbox"/> DVT                   | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Polio                             |
| <input type="checkbox"/> Ankylosing Spondylitis    | <input type="checkbox"/> EENT Problems         | <input type="checkbox"/> Neuropathy            | <input type="checkbox"/> Poor Circulation/Vascular         |
| <input type="checkbox"/> Anxiety                   | <input type="checkbox"/> Fracture Hip          | <input type="checkbox"/> Hypothyroidism        | <input type="checkbox"/> Pulmonary Embolism                |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Fibromyalgia          | <input type="checkbox"/> Liver Problems        | <input type="checkbox"/> Reflex/Ulcers                     |
| <input type="checkbox"/> Bleeding Disorder         | <input type="checkbox"/> GI Bleed              | <input type="checkbox"/> Lupus                 | <input type="checkbox"/> Rheumatoid Arthritis              |
| <input type="checkbox"/> Bowel or Bladder Problems | <input type="checkbox"/> Heart Problems: _____ | <input type="checkbox"/> Mental Illness        | <input type="checkbox"/> Seizures                          |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Sleep Apnea                       |
| <input type="checkbox"/> COPD                      | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Osteoarthritis        | <input type="checkbox"/> Stroke                            |
| <input type="checkbox"/> Depression                | <input type="checkbox"/> HIV                   | <input type="checkbox"/> Psoriasis             |  |

Has anyone in your family been diagnosed with any of the following illnesses?

- |  |                                     |   |  |   |  |
|--|-------------------------------------|---|--|---|--|
| <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Hypertension            | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Rheum Arthritis |
| <input type="checkbox"/> Bleeding Disorder   | <input type="checkbox"/> Cancer     | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lung/Breathing Problems | <input type="checkbox"/> Osteoporosis   | <input type="checkbox"/> Stroke          |

List medications you are currently taking, the dosage, and how often you take them:  No meds being taken

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

**\*\*DRUG ALLERGIES\*\* (Check if yes)**

- Aspirin  Cortisone  Marcaine / Lidocaine / Novocain  Sulfa  Codeine  Betadine  Penicillin  Tape  
 Morphine  Nickel  Other, please specify \_\_\_\_\_  NO KNOWN ALLERGIES

\_\_\_\_\_  
Patient Date of Birth

X \_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Today's Date