Patient History/Problem List

Patient Name:___________________________ Date:_____________________

Date of Birth:_____/_____/_____________ Physician:________________

Initial Eval:___/___/___________________ Date of Next Physician Visit?___/___/________

A. Personal Medical History:

1. Please Circle all conditions which you have or have had in the past:

Allergies
Angina/chest pain
Arthritis
Asthma/breathing disorders
Back pain
Blood disorders
Bowel/bladder disorder
Cancer___________________
Diabetes
Dizziness/fainting
Eating disorders
Epilepsy/seizures
Fractures
Head aches
Hearing difficulty
Heart conditions/disease
Hepatitis
Hernia
High blood pressure
HIV positive
Hypoglycemia
Kidney disease
Liver/gallbladder disease
Lyme disease
Meningitis
Multiple Sclerosis
Neuritis
Osteoporosis
Pacemaker
Parkinson's Disease
Phlebitis
Pregnant
Ringing in ears
Stroke
Tuberculosis
Other_____________________

2. Allergies (specify):____

3. Medications:____

4. Implants(metal/plastic):____

5. Diagnostic tests/procedures:____

6. Surgeries:____

B. Present Medical History:

1. Date of injury/ start of symptoms:____/____/_________________

2. Have you ever had these symptoms before? Y / N

3. Do you currently have pain? Y / N

4. How would you rate your pain? 0-1- 2 - 3 - 4- 5 -6-7 -8 - 9 -10
   (0 = no pain   5 = moderate pain   10 = severe pain)

5. Does anything make your pain better?

6. Does anything make your pain worse?

7. Please indicate where your symptoms are located?

8. Circle which apply to your symptoms:

work related	recurrence of previous injury
related to fall	motor vehicle accident
athletic/recreational	related to lifting
daily activities	other:___________________

9. Have you had a related surgery? Y / N

10. Are you presently employed/working? Y / N

11. Do you plan on returning to work? Y / N

Date   Signature   Relationship to patient