History Form DATE **Patient name** Birth date: Age: Acct._____

Gender: ☐ M ☐ F ☐ Right handed ☐ Left handed Height / Weight: _____/____ lbs Shoe size: ___

Primary care physician: _____ Referred by: _____

Reason for today's visit: _____

Date of injury / onset of pain (required)_____ Is your pain/injury a result of an accident? ☐ Yes ☐ No

How did the accident occur? _____

Is this a work-related injury? (required) ☐ Yes ☐ No If yes, did you notify your employer? ☐ Yes ☐ No

Did you file a Workers' Comp Claim ☐ Yes ☐ No Are you still working? ☐ Yes ☐ No If no, last day worked? _____

ACTIVE or CURRENT CONDITIONS / SYMPTOMS

	Yes	No
Allergic reaction to foods or environment (detail)_____	☐	☐
Blood related -- easy bruising, anemia, clotting disorder, other _____	☐	☐
Bones and/or muscles -- pain, swelling, stiffness, instability _____	☐	☐
Cardiovascular -- chest pain, palpitations, fainting, murmurs, other _____	☐	☐
Ears, Nose, Throat -- headache, difficulty swallowing, nose bleeds, ringing in ears, other _____	☐	☐
Endocrine -- excessive thirst or urination, heat/cold intolerable, other _____	☐	☐
Eyes -- corrective lenses, blurred vision, eye pain, redness, other_____	☐	☐
Gastrointestinal -- heartburn, nausea, constipation, diarrhea, other_____	☐	☐
General -- unexpected weight loss/gain, fever, fatigue, other _____	☐	☐
Genitourinary – frequent/urgent/difficult painful urination, flank pain, bleeding, other_____	☐	☐
Integumentary -- skin changes, poor healing, rash, itching, redness, nodules, other_____	☐	☐
Lymphatic -- swollen glands, enlarged lymph nodes, other _____	☐	☐
Neurologic -- numbness/tingling, unsteady gait, tremors, seizure, other_____	☐	☐
Psychiatric -- nervousness, anxiety, depression, hallucinations, other _____	☐	☐
Respiratory -- short of breath, wheezing, cough, tightness, snoring, other _____	☐	☐

PAST MEDICAL HISTORY: (specify conditions)

	Yes	No	Onset Date
Blood disorder _____	☐	☐	_____
Cancer primary/metastatic _____	☐	☐	_____
Diabetes Type 1 Type 2 _____	☐	☐	_____
Ear, nose, throat disorder _____	☐	☐	_____
Eye disorder _____	☐	☐	_____
Gastrointestinal disorder _____	☐	☐	_____
Heart disease _____	☐	☐	_____
High cholesterol_____	☐	☐	_____
HIV positive_____	☐	☐	_____
Hypertension _____	☐	☐	_____
Kidney, bladder, prostate, menopause (age) _____	☐	☐	_____
Muscle or bone disorder_____	☐	☐	_____
Neurological disorder_____	☐	☐	_____
Peripheral vascular disease _____	☐	☐	_____
Psychiatric disorder _____	☐	☐	_____
Respiratory disorder_____	☐	☐	_____
Sexually transmitted disease _____	☐	☐	_____
Skin disorder _____	☐	☐	_____
Thyroid disorder_____	☐	☐	_____
Other medical condition_____	☐	☐	_____

OVER

History Form DATE **Patient name** Birth date: Age: Acct._____

SURGICAL HISTORY: ☐ see attached list

List ALL surgeries with dates.

_____

_____

_____

CURRENT MEDICATIONS: ☐ see attached list **PHARMACY:** _____

List ALL prescriptions, over-the-counter drugs, and any supplements. **List the name, reason, dosage, and frequency**.

_____

_____

_____

_____

_____

DRUG ALLERGIES (drug and reaction):_____

_____

_____

FAMILY HISTORY: Major medical conditions or cause of death

Mother	☐ Alive	☐ Deceased	_____
Father	☐ Alive	☐ Deceased	_____
Siblings	☐ Alive	☐ Deceased	_____
	☐ Alive	☐ Deceased	_____
	☐ Alive	☐ Deceased	_____
Other relation	☐ Alive	☐ Deceased	_____
	☐ Alive	☐ Deceased	_____
	☐ Alive	☐ Deceased	_____

SOCIAL HISTORY:

Occupation: _____

Marital Status: ☐ S ☐ M ☐ W ☐ D Do you live alone or with family?: _____

Do you smoke? ☐ Y ☐ N Packs per day: ___ years: ___ Did you quit smoking? ☐ Y ☐ N When? _____

Do you use alcohol? Y N Type: _____

☐ Social ☐ Moderate 1 a day women, 2 a day men ☐ Other ___ per day or ___ per week average

Substance abuse? ☐ Y ☐ N Type: _____

___x per day or ___x per week average Did you quit? ☐ Y ☐ N When? _____

Do you exercise? Y N Type: _____

___x per day or ___x per week average

Activities or sports you're involved in: _____

_____

_____

_____

Patient/parent signature:_____ Date:_____

Ortho tech signature: _____

Physician signature: _____ Date:_____