PATIENT CONFIDENTIAL MEDICAL HISTORY **TODAY'S DATE: _____________**

Patient Name: ____ DOB: ________________ Age: _________

Height: ________ Weight: ________ Marital Status: Married Widow/er Dependent Domestic Partner

How many people live with you? Adults _____ Children _____

Occupation: ____________________________ Retired Student Employer: _____________________________________

CHIEF COMPLAINT

Reason for visit: Pain / Numbness / Weakness / Other ___________________ Any labs or x-rays? _______________

What body part is involved? _______________________________ What side? Right / Left / Both

How long has this problem been present? ____________________ Days / Weeks / Months

Have you been seen by someone else for this problem? Yes / No Who? ____

How did your problem start? No Injury / Injury (Date of Injury: _________) / Gradual / Sudden

Please explain:

____
____
____
____
____

The pain is: Constant / Comes and goes (intermittent)

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10

What does the pain feel like?: Sharp / Dull / Stabbing / Throbbing / Aching / Burning

Other, please explain: _____________________________________

Are there other symptoms?: Swelling / Numbness / Weakness

Since my problem started, it is: Getting better / Getting worse / Unchanged

What makes your symptoms worse?: Activity / Exercise / Work

Other, please explain: _____________________________________

What makes your symptoms better?: Rest / Heat / Ice / Elevation

Other, please explain: _____________________________________

What medications have you taken or been prescribed for this problem?

____

Which if any treatments have you tried?: Injections / Bracing / Physical Therapy / Cane / Crutch / Other

____

Patient Signature: ____ Date: ____________________________