



**PATIENT HISTORY FORM**

**Patient Name:** \_\_\_\_\_ **DATE** \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_

1. What is your main symptom and when did it first begin? Right or Left? \_\_\_\_\_  
\_\_\_\_\_
2. Is this related to a work injury? (circle one) Yes No
3. Is this related to an automobile accident? (circle one) Yes No
4. Please note **any and all surgical procedures, or hospitalizations** with dates and any serious injuries:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. What other medical (non-surgical) conditions do you have? \_\_\_\_\_  
\_\_\_\_\_
6. **List all medications, EXACT dosage and daily schedule currently used** (including diet pills, drops, inhalers, herbal supplements, and aspirin type products etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Please note **allergies to medications:** \_\_\_\_\_
8. Have you had blood transfusion? Grafted tissues? Implanted hardware? (please describe):  
\_\_\_\_\_
9. History of: Hepatitis? or HIV exposure? \_\_\_\_\_
10. Any significant illnesses known to run in the family? (please describe): \_\_\_\_\_  
\_\_\_\_\_
11. If you are currently or were ever employed, please briefly explain your position/duties including lifting, climbing and operating dangerous equipment: \_\_\_\_\_  
\_\_\_\_\_
12. If you are retired, from what and how long ago? \_\_\_\_\_
13. If you smoke(d), how much? \_\_\_\_\_ If you quit, how long ago? \_\_\_\_\_
14. Do you drink alcohol? \_\_\_\_\_ How often and how much? \_\_\_\_\_
15. Do you use recreational drugs?  
\_\_\_\_\_

Please note any health complaints not covered above such as weight loss, rashes, shortness of breath, irregular heart beats, chest pain, stomach cramps, constipation, blood in stool, urine or sputum; fever, chills etc.

**My signature verifies that the above information is complete and accurate.**

**Patient Signature** \_\_\_\_\_ **DATE** \_\_\_\_\_

Reviewed with Patient By: \_\_\_\_\_ **DATE** \_\_\_\_\_  
Doctor Signature/Initials

/form - pt. history/ revised 9/0