



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