

HEALTH HISTORY

Office use only:

Vital Signs: Temp _____ Ht. _____ Wt. _____

Patient Name: _____ DOB: _____ AGE: _____

Referred by: _____ PCP: _____

Reason for today's visit _____

Related to: MVA Slip and Fall W/C claim Injury Date: _____

WHERE IS THE PAIN LOCATED: _____

HOW SEVERE ARE THE SYMPTOMS: Mild Moderate Severe

SYMPTOM START DATE: _____

What Makes It Better/Worse? _____

Past History:

Hypertension Diabetes Heart Disease Lung Disease High Cholesterol Cancer

Diseases: HIV TB Hepatitis A B C D (If yes, circle which one)

Previous Surgeries/Hospitalizations:

Please indicate any personal history below:

Const: Fatigue Weight loss/gain Fever

Eyes: Vision Change Glasses Contacts

ENT: Hearing loss Vertigo Chronic sinus problems Sore Throat

CV: Heart disease Chest pain Palpitations Shortness of Breath Feet swelling

Resp: Shortness of Breath Cough Wheezing

GI: Nausea/vomiting Diarrhea Constipation Abdominal Pain

GU: Frequent urination Blood in Urine Kidney Stones

M/S: Muscle weakness/pain/cramps Back pain Bone pain Fractures

Skin Rash Itching Lesions Bruising Nail changes Tattoos Scars

Neuro: Numbness/tingling Headaches Head injury

Heme: Easy Bruising Blood clots Anemia

Family History:

Hypertension Cardiac Disease Cancer Diabetes

Other _____

Social History:

Marital S M D W

Alcohol _____ Drugs _____

Are you pregnant: YES NO

Smoking No Yes how long _____

Allergies to medicines: _____

Signature

Date