HEALTH HISTORY FORM

Jason P. Young, MD

PATIENT INFORMATION

Name: _____ Nickname: _____ Date: _____

DOB: _____ Age: _____ Gender: _____ Height: _____ Weight: _____

Are you pregnant? ☐ YES ☐ NO Are you: ☐ Right Handed ☐ Left Handed

Who referred you to us: _____

Who is filling in form: _____ Signature: _____ Relation: _____

INJURY DETAILS

Are symptoms related to an injury? ☐ Y ☐ N Work related? ☐ Y ☐ N Auto accident? ☐ Y ☐ N

Date of injury: _____ Are you represented by an attorney? ☐ YES ☐ NO

Attorney name/address: _____ State of accident/injury: _____

Employer: _____ Occupation: _____

PROBLEM DETAILS

Body Part to be examined: _____ ☐ RIGHT ☐ LEFT

Date of symptom onset: _____ Current pain score (1-10): _____ Pain score at worst: _____

How did the problem begin (specifically): _____

_____

What activities make pain worse: _____

What makes pain better: _____

Describe pain: ☐ Ache ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Tingling ☐ Burning other: _____

Do you have: ☐ Weakness ☐ Stiffness ☐ Loss of motion ☐ Locking ☐ Catching ☐ Giving way ☐ Popping

Who have you seen for this: ☐ ER/Urgent Care ☐ Family Dr. ☐ Work Comp Dr. ☐ Chiro ☐ PT

Have you seen a surgeon for this: ☐ YES ☐ NO Whom/when: _____

Previous treatments: ☐ Ice ☐ Compression ☐ Bracing ☐ PT ☐ Chiropractor ☐ Massage ☐ Injections

IMAGING HISTORY

Please list details of all imaging / tests performed: ☐ XRAY ☐ MRI ☐ CT ☐ EMG ☐ Bone Scan

-Date: _____ Location of test: _____ Result: _____

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MEDICAL TEAM

Who is your primary care provider: _____ Phone #: _____

Preferred pharmacy name/location: _____ Phone #: _____

ALLERGIES

Are you allergic to any medications? ☐ Y ☐ N **Adhesives?** ☐ Y ☐ N **Metal/jewelry?** ☐ Y ☐ N

Please list all allergies: _____

MEDICATIONS

Please list all current medications (include prescriptions, over-the-counter & supplements):

Medication name	*Dose*	*Medication name*	*Dose*
_____		_____	
_____		_____	
_____		_____	

MEDICAL HISTORY

Please mark all <u>current</u> & <u>past</u> medical conditions:

CV: ☐ Heart disease ☐ Heart attack ☐ Irregular heart beat ☐ Stroke

Pulm: ☐ Lung disease ☐ COPD ☐ Asthma ☐ Sleep apnea

GI: ☐ Ulcers ☐ Crohn's/UC ☐ Gastric bleeding

GU: ☐ Kidney disease **ID:** ☐ Hepatitis ☐ HIV/AIDS ☐ TB

Endo: ☐ Diabetes (A1c:_____) **Heme:** ☐ Blood clots

Onc: ☐ Cancer (type:_____)

Neuro: ☐ Seizure disorder ☐ Neuropathy

MSK: ☐ Lupus ☐ Rheumatoid arthritis ☐ Gout ☐ Fibromyalgia ☐ Osteoporosis

Psych: ☐ Depression ☐ Anxiety ☐ Bipolar

Please list any other medical conditions not already listed:

_____

_____

_____

_____

SURGICAL/HOSPITAL HISTORY

Please list all past surgeries and hospitalizations:

Surgery/Condition	*Date*	*Surgery/Condition*	*Date*
_____		_____	
_____		_____	

SOCIAL HISTORY

Do you smoke? ☐ YES ☐ NO Packs per day: _____ For how long: _____ Quit date: _____

Do you drink alcohol? ☐ YES ☐ NO Drinks per week:_____ **Do you use rec. drugs?** ☐ YES ☐ NO

FAMILY HISTORY

Do you have a family history of blood clots? ☐ YES ☐ NO

Has any one in your family had a significant reaction to anesthesia? ☐ YES ☐ NO

If yes, please explain: _____