

**Peus, Birch, Kahmann, Gallivan and Romero
A Medical Corporation**

History and Physical Information

Name: _____ Date: ____/____/____

Age: _____ Height: _____ Weight: _____ B/P: _____ Pulse: _____ Temp: _____

Hand Dominance: Right Left Date of Injury: ____/____/____

I. History of your Injury

Which body part is to be examined? _____

Did the problem result from a specific injury? Yes No Injury/Accident Date: ____/____/____

Did your problems begin following: Work injury? Motor Vehicle Accident?

How did you get injured? _____

If neither, how long have you had the condition? _____

Please rate your pain on a scale of 1 to 10 (indicate with an "X")

Pain at rest:	None	0	1	2	3	4	5	6	7	8	9	10	Severe
Pain with activity:	None	0	1	2	3	4	5	6	7	8	9	10	Severe

Is the pain: Constant Occasional Sharp Dull Aching Stabbing Throbbing

What symptoms are you experiencing? Locking Catching Giving Way Popping
 Grinding Other: _____

What, if anything, makes your symptoms better? _____

What, if anything, makes your symptoms worse? _____

Have you seen other physicians for this injury? Yes No

If yes, who? _____

What treatments have you tried? Nothing Physical Therapy Bracing Chiropractic
 Injections Surgeries If surgery, please specify: _____
 Medications: _____

Have you had any of the following tests?

Test	Date (month/year)	What Facility? (clinic/hospital)
<input type="checkbox"/> X-rays	_____	_____
<input type="checkbox"/> MRI Scan	_____	_____
<input type="checkbox"/> CT Scan	_____	_____
<input type="checkbox"/> EMG/NCV	_____	_____
<input type="checkbox"/> Blood tests	_____	_____
<input type="checkbox"/> Other	_____	_____

II. Past Medical History

Please check current or previous medical conditions:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemical Dependency
and/or alcoholism | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Arthritis | | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Concussion | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke/Seizures | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Thyroid | |

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II. Past Medical History (continued)

Other: _____

Have you ever had a blood transfusion? Yes No If yes, when? _____

III. Past Surgical History

Please check any previous surgical procedures, list the date and describe surgery:

- Appendectomy Hernia Repair Arthroscopy Lower Extremity Upper Extremity
 Spine/Back Surgery Heart Surgery Total Joint Replacement Fracture Repair

Other: _____

IV. Medications

<i>Medication</i>	<i>Dosage</i>	<i>Frequency</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

V. Allergies

Are you allergic to any medication? **PCN** Yes No **Sulfa** Yes No **Latex** Yes No
 No known drug allergies.

List all other medications you are allergic to: _____

VI. Gastrointestinal History

Do you have a history of peptic Ulcer Disease? Yes No If yes, when? _____

Do you have a history of GI or stomach bleed? Yes No If yes, when? _____

Do you take any medications for your stomach? Yes No

(Please include over the counter medications: i.e. Pepcid, Tums, Zantac, etc., dosage and frequency)

Have you ever taken anti-inflammatory medicine for a period greater than 30 days? *(Please include over the counter medications such as Advil, Aleve, and previously prescribed medications such as Celebrex, and Vioxx. List all you have tried.)*

VII. Social History

Tobacco Use: Yes No Type: _____ Duration: _____ Quit Date: ___ / ___ / ___

Alcohol Use: Yes No Frequency: _____

Recreational Drug Use: Yes No Type: _____
Frequency: _____

Caffeine Use: Yes No Frequency: _____

Regular exercise? Yes No Type of exercise you enjoy? _____

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VIII. Family History

Please check family history condition:

- | | | | |
|--------------------------------------|--|---------------------------------------|---|
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke/Seizure |

Please describe any immediate family history of medical problems: _____

IX. Review of Systems

1. **Constitutional General**
 None Weight Loss Weight Gain Insomnia Chronic Fatigue
 Other : _____
2. **Eyes**
 None Vision Changes Glasses/ Contacts Cataracts
 Glaucoma Other : _____
3. **Ears, Nose, Throat**
 None Loss of Hearing Seasonal Allergies Sinus Pain
 Ringing Other : _____
4. **Cardiovascular**
 None Chest Pain Edema Hypertension Palpitations
 High Cholesterol Other : _____
5. **Respiratory**
 None Asthma Wheezing Frequent Cough Shortness of Breath
 Other : _____
6. **Gastrointestinal**
 None Heartburn Indigestion Acid Reflux Ulcer Problems
 Abdominal Pain Peptic Ulcer GI, Stomach Bleed
 Other : _____
7. **Musculoskeletal**
 None Arthritis Muscle Weakness Joint Pain Back Pain
 Other : _____
8. **Skin**
 None Rash Ulcers Scars
 Other : _____
9. **Neurological**
 None Headaches Seizures Numbness Dizziness
 Other : _____
10. **Psychiatric**
 None Depression Crying Anxiety Mood Swing
 Other : _____
11. **Endocrine**
 None Diabetes Hypothyroid Hyperthyroid Hot flashes
 Other : _____
12. **Hematology**
 None Easy Bruising Bleeding Anemia
 Other : _____

Signature: _____ Date: _____

Print Name: _____