

Medical History
Dr. William R. Gallivan, Jr, MD

Name: _____ Date: _____ DOB: _____ Age: _____

Height: _____ Weight: _____ Hand Dominance: R or L Date of Injury/Onset: _____

Allergies (Medication or Metals Allergies): _____ PCN // Sulfa // Latex

Family physician or other physician: _____

HISTORY OF YOUR INJURY:

Which body part is to be examined? _____

How did you get injured? _____

Did your problem begin following: Work injury? _____ Motor vehicle accident? _____

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

PLEASE RATE YOUR PAIN:

<i>None</i>	<i>0</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>9</i>	<i>10</i>	<i>Severe</i>
<i>None</i>	<i>0</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>9</i>	<i>10</i>	<i>Severe</i>

At rest: _____ Night Pain: _____ Pain with Activity: _____ Worse doing: _____

Is the pain: Constant: _____ Occasional: _____ Sharp: _____ Dull: _____ Aching: _____ Stabbing: _____ Throbbing: _____

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

Have you ever seen a physician for this injury before? YES /// NO If yes, who: _____

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

MEDICAL HISTORY:

Have you had any of the following tests?

TEST	Date (month/year)	What Facility? (Clinic/hospital)
XRAYs		
MRI/CT SCAN		
EMG/NCV		

History of previous fractures & dates: _____

History of surgeries & dates: _____

Current Medications/Vitamins (please include dosage & frequency): _____

**ANY PREVIOUS HISTORY OF BLOOD CLOTS: YES /// NO Dates: _____

Please check below if any of these apply to you:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Pulmonary Embolus | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Strokes/Seizures | <input type="checkbox"/> Recent weight loss |
| <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Sex Dysfunction | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding/clotting | <input type="checkbox"/> Claustrophobic | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Bloody urine | <input type="checkbox"/> Fainting Problems | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Lapse of memory | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Urination problems | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> HIV | <input type="checkbox"/> Shaking/twitching |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Calf cramps w/walking | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High/Low BP |
| <input type="checkbox"/> Emotional illness | <input type="checkbox"/> History of Infections | | |

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 If yes, What? _____

SOCIAL HISTORY:

Please indicate your use of the following:

Cups of coffee per day: _____ Alcoholic drinks per day: _____ Tobacco use per day: _____ Recreational Drugs: _____

Hobbies you have: _____

What sports or activities do you participate in? _____

What are your athletic goals? _____

FAMILY HISTORY:

Family history of medical conditions: _____ Death before age 50: Yes ___ No ___

If you put a check next to any of the above items, please explain: _____

PAIN DRAWING:
(Please Indicate Location of Pain)

