ALL ACCESS **ORTHO**

HEALTH HISTORY FORM

FOR OFFICE USE ONLY:
Acct #
Imaging:
WC/NF
Ins Co:
Adjuster:
Employer:
DOI:
Claim #:

NAME: _____

DATE: _____

AGE: _____ **SEX:** _____ **DOB:** _____

Primary Care Physician: _____

Referred By: _____

What is your chief symptom or problem? _____

Location of pain/problem? _____

What factors make pain/problem worse? _____

When did the pain/problem start (date)? _____

Please rate the severity or intensity of pain (circle number)

0 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

The pain is present: Constantly_____ Intermittently At night_____

The quality of pain is: Sharp_____ Dull_____ Burning_____ Other_____

How did symptoms/condition start? _____

_____

_____

SYSTEMS REVIEW

Recent cold or flu?	No_____	Yes_____	Recent intestinal problems?	No_____	Yes_____
Recent eye or ear problems?	No_____	Yes_____	Recent urinary problems?	No_____	Yes_____
Recent skin problems?	No_____	Yes_____	Recent bleeding problems?	No_____	Yes_____
Recent heart problems?	No_____	Yes_____	Recent nerve problems?	No_____	Yes_____
Recent breathing problems?	No_____	Yes_____	Recent depression?	No_____	Yes_____

High School Attended: _____ College attended: _____

HEIGHT _____ **WEIGHT:**_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? None_____ Yes_____ (please list)

1.	4.	7.
2.	5.	8.
3.	6.	9.

LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING

1.	4.	7.
2.	5.	8.
3.	6.	9.

MEDICAL HISTORY

Coronary heart disease	No_____	Yes_____	
High blood pressure	No_____	Yes_____	
Heart attack	No_____	Yes_____	
Stroke	No_____	Yes_____	
Diabetes	No_____	Yes_____	
Cancer	No_____	Yes_____	Type: _____
Asthma	No_____	Yes_____	
Gastric reflux	No_____	Yes_____	
Ulcer	No_____	Yes_____	

Other: _____

LIST SURGERIES YOU HAVE HAD: (GIVE APPROX DATE & SURGEON)

1.	4.	7.
2.	5.	8.
3.	6.	9.

OCCUPATION: _____

Do you smoke? No_____ Yes_____ How many cigarettes per day? _____ If quit smoking, when did you quit?_____

Do you drink alcohol? No_____ Yes_____ Yes, number of drinks per: day_____ week_____ month_____

Do you have a history of recreational drug use? No_____ Yes_____ Yes, what drug? _____

FAMILY HISTORY: (please mark with an "X" if your mother or father has a history of diseases below)

	Heart attack	Diabetes	Stroke	Cancer
Mother	_____	_____	_____	(Type)_____
Father	_____	_____	_____	(Type)_____