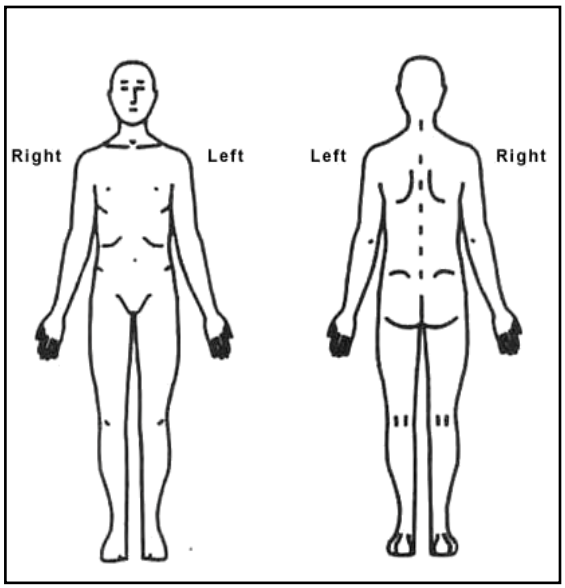
MUSCULOSKELETAL CENTER

History Form

MedicalCenter/Clinic
HEALTHCARE CENTERED AROUND YOU

Name: _____Age: _____
Height: _____ Weight: _____ Referring Physician: _____
Reason for today's visit: _____



1. On a scale of 0 to 10, what is your pain today_____
2. Describe the quality of your pain, *please circle all that apply*:
   Aching Gnawing Pressure Stinging Drilling Heaviness Raw
   Throbbing Burning Tightness Cold Nagging Shock-like Sharp
   Exhausting Cramping Penetrating Shooting Other: _____
3. Does the pain radiate? _____ Yes _____ No
   If "yes", where does the pain radiate to:_____
4. How long has the current condition been present? _____
   Date of onset: _____
5. How did the problem begin? Gradual onset Sudden onset After surgery
   Accident / Injury Accident / Injury date: _____
   Please describe the accident / injury: _____
6. Injury / Illness aggravated by: _____
   Injury / Illness Relieved by: _____
7. Have you had a problem like this in the past? If so, when? _____
8. Please list all the diagnostic tests and treatments that have been performed for the problem that we are seeing you for today (please provide when / where / what):
   _____

REVIEW OF SYSTEMS

*Please circle **Yes** or **No** for each symptom listed below. **Do not leave any blanks.***

Constitutional

Recent Weight Changes	*Yes*	*No*
Chills or Fever	*Yes*	*No*
Fatigue	*Yes*	*No*
Hot or Cold Spells	*Yes*	*No*

Respiratory

Morning Cough	*Yes*	*No*
Shortness of Breath	*Yes*	*No*

Cardiovascular

Heart or Chest Pain	*Yes*	*No*
Abnormal Heartbeat	*Yes*	*No*
Badly Swollen Ankles	*Yes*	*No*
Calf Cramps	*Yes*	*No*

Gastrointestinal

Poor Appetite	*Yes*	*No*
Nausea/ Vomiting	*Yes*	*No*
Abdominal Pain	*Yes*	*No*
Constipation/ Diarrhea	*Yes*	*No*

Endocrinologic

Intolerance to Heat & Cold	*Yes*	*No*
Menstrual Irregularities	*Yes*	*No*
Frequent Hunger/Thirst/Urination	*Yes*	*No*

Musculoskeletal

Joint Pain/Swelling	*Yes*	*No*
Joint Stiffness	*Yes*	*No*
Limited Use of a Joint	*Yes*	*No*
Bone Deformities	*Yes*	*No*
Muscle Cramping/Pain	*Yes*	*No*
Loss of Muscle Strength	*Yes*	*No*

Genitourinary

Frequent Urination	*Yes*	*No*
Burning on Urination	*Yes*	*No*
Incontinence	*Yes*	*No*

Neurological

Frequent Headaches	*Yes*	*No*
Blackouts	*Yes*	*No*
Seizures	*Yes*	*No*
Tremors	*Yes*	*No*
Loss of Bowel	*Yes*	*No*
Difficulty Balance	*Yes*	*No*

Immunologic

Seasonal Allergies	*Yes*	*No*
Frequent Infections	*Yes*	*No*
HIV Exposure	*Yes*	*No*

Please turn over and complete page 2

Integumentary			***Psychiatric***		
Rashes	*Yes*	*No*	*Anxiety*	*Yes*	*No*
Lumps	*Yes*	*No*	*Depression*	*Yes*	*No*
Itching	*Yes*	*No*	*Memory Loss*	*Yes*	*No*
Dryness	*Yes*	*No*	*Stress*	*Yes*	*No*
Hematologic			***HEENT***		
Excessive Bleeding	*Yes*	*No*	*Difficulty Hearing*	*Yes*	*No*
Easy Bruising	*Yes*	*No*	*Ringing in Ears*	*Yes*	*No*
Anemia	*Yes*	*No*	*Sore Throat*	*Yes*	*No*
			Nasal Bleeding	*Yes*	*No*

PATIENT'S MEDICAL HISTORY *Please circle all that apply.*

AIDS/HIV, Alcoholism, Alzheimer's, Anemia, Angina, Arthritis, Asthma, Atrial Fibrillation, Benign Prostatic Hypertrophy, Cancer, Congestive Heart Failure, COPD, Coronary Heart Disease, Crohn's Disease, Depression, Degenerative Joint Disease, Depression, Diabetes, Drug Abuse, DVT, Fibromyalgia, Gallbladder Disease, GERD, Gout, Hepatitis, Hyperlipidemia, Hypertension, Inflammatory Bowel Disease, Juvenile Rheumatoid Arthritis, Kidney Disease, Liver Disease, Lyme Disease, Migraine Headaches, Myocardial Infarction (heart attack), Obesity, Osteoporosis, Peptic Ulcer Disease, Psoriasis, PVD, Renal Disease, Rheumatoid Arthritis, Scoliosis, Seizure Disorder, SLE (Lupus), Sleep Apnea, Stroke, Thyroid Disease,

NONE OTHER:_____

SOCIAL HISTORY Please circle all that apply.

Smoking or use of tobacco products: Never Former Years of use_____ Number of packs or products per day _____ Date Last Used _____

Alcohol: None Occasionally Recreationally Everyday Recreational Drug Use: None Occasionally Presently Past Problem

Hand Dominance: Right Left Ambidextrous

SURGICAL HISTORY

Please include approximate dates. *No Prior Surgeries*

_____

_____

ALLERGIES

Medication / Other Substance:	Reaction:	Severity of Allergy: *(please circle)*			
_____	_____	Mild	Moderate	Severe	Intolerable
_____	_____	Mild	Moderate	Severe	Intolerable
_____	_____	Mild	Moderate	Severe	Intolerable
_____	_____	Mild	Moderate	Severe	Intolerable

CURRENT MEDICATION LIST

Please include all medications prescribed by a physician, any over-the-counter (OTC) medications, any herbal supplements, and vitamins. ***NONE***

_____

_____

_____

_____

PREFERRED PHARMACY NAME AND LOCATION _____

_____