

Patient History Form

Name: _____ Today's Date _____ Date of Birth _____

Who referred you to this office? _____

Why are you seeing the doctor today? _____

Was this a result of an injury? _____ Date _____

Current problem is the result of a(n): **Check** all that apply

- Car Accident School Accident Other/Sports Team

Which team/school _____

Medications/ Dose	Reason	Side Effects
Surgery/ Hospitalizations	Year	Complications

All immunizations up to date? Yes No If no, which immunizations are due?

Review of Systems Are you currently having or have you had problems with your

Eyes	No	Yes	Ears, Nose, Throat	No	Yes
Lungs Breathing	No	Yes	Digestion	No	Yes
Bowel movement	No	Yes	Bladder problem	No	Yes
Diabetes	No	Yes	High blood pressure	No	Yes
Heart	No	Yes	Bleeding problems	No	Yes
Balance problem	No	Yes	Numbness/tingling	No	Yes
Blackout/fainting	No	Yes	Psychological problems	No	Yes
AID	No	Yes	Cancer	No	Yes
Arthritis	No	Yes	Polio	No	Yes
TB	No	Yes	Epilepsy	No	Yes

Have you ever had general anesthesia? No Yes Describe complications: _____

Please explain all YES responses _____

Significant Family Medical History _____

How many times a week do you participate in sports? _____

Patient's Signature or Guardian if patient is a minor
 _____ Date _____

Reviewed by: _____ **MD** **Date** _____