

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Today's ailment (brief description of onset): \_\_\_\_\_

\_\_\_\_\_ Affected side: Left Right  
Date of injury or onset of problem: \_\_\_\_\_ Dominant hand: Left Right

What is your occupation? \_\_\_\_\_

Work related? Yes No Auto accident? Yes No Attorney involved? Yes No

Have you had x-rays taken? Yes No If yes, where? \_\_\_\_\_

Have you had an MRI? Yes No If yes, where? \_\_\_\_\_

**Drug Allergies:** Yes No Please list drug and reaction: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Daily Medications:(please include pain meds, herbs, vitamins & OTC)

Name Dose/Strength Times per day

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Past Surgical History: (List type and date)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Past Medical/Hospital History: (Illnesses/conditions)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you now or have you ever had.....		
Anemia.....	Yes	No
Diabetes.....	Yes	No
Cancer/Type.....	Yes	No
Kidney/Bladder trouble.....	Yes	No
High Blood Pressure.....	Yes	No
Heart Trouble.....	Yes	No
Bleeding Disorder.....	Yes	No
Asthma.....	Yes	No
Neurologic Disorder/Seizures.....	Yes	No
Depression.....	Yes	No
Stroke.....	Yes	No
Thyroid Disorder.....	Yes	No
Ulcer/Stomach Problems.....	Yes	No
Hepatitis.....	Yes	No
Arthritis/Gout.....	Yes	No
Phlebitis/Blood Clots.....	Yes	No
AIDS/HIV.....	Yes	No
Substance Abuse.....	Yes	No

Do you exercise? Examples: running, ride bike, cardiovascular, etc.  
Yes No How often? \_\_\_\_\_ What type? \_\_\_\_\_

Do you smoke? Yes No Packs per day? \_\_\_\_\_ For how many years? \_\_\_\_\_

Do you drink alcohol? Yes No If yes, average consumption per week? \_\_\_\_\_

Are you now or could you possibly be pregnant? Yes No

Has any blood relative younger than 50 ever had unusual bleeding tendencies? Yes No  
If yes, who and what is their age: \_\_\_\_\_

*The above information is, to the best of my knowledge, a true statement of my current condition.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_