Mercy

PATIENT HISTORY FORM

Please print - it is very important that you fill out completely - no question should be left unanswered

NAME: _____ DOB: _____ DATE: _____

AGE:_____ OCCUPATION:_____ Are you Right or Left handed *(circle one)*?

Is the injury due to motor vehicle accident? ❑ yes ❑ no State which MVA happened _____

Is the injury due to a 3rd party accident? ❑ yes ❑ no

Have you filed a work comp claim or accident report with your employer? ❑ yes ❑ no

Name of employer (only if work related)_____

Is the injury sports related? ❑ yes ❑ no What sport(s) do you play? _____

Chief Complaint: What are we seeing you for today *(please list if it is right or left)?*_____

Date of Injury: _____ **How did your symptoms begin?** _____

Has injury/problem gotten: better, worse or the same? *(circle all that apply)* Anything that makes it better or worse?

_____

Are your symptoms: Annoying Painful Intermittent Constant Numb Tingling *(circle all that apply)*

When does the problem occur? Day, Night, with activity, at rest, with certain activities *(circle all that apply)*

Have you had any prior injury or treatment to this area? ❑ yes ❑ no If yes tell us about any prior surgery or treatment you have received for this or any related condition. _____

_____

For the problem you are being evaluated for **TODAY**, have you had any of the following tests?

(circle all that apply) X-rays MRI Nerve Studies CT Scans When?_____ Where?_____

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? ❑ yes ❑ no ❑ maybe ❑ does not apply

ALLERGIES: ❑No medication allergies

Are you allergic to Latex ❑ yes ❑ no

PLEASE LIST ALL **MEDICATION ALLERGIES** AND THE **REACTION** YOU HAVE:

_____

_____

_____

Have you or anyone in your family ever had trouble with anesthesia? ❑ yes ❑ no

Pharmacy Name:_____ **Location**:_____

Primary Care Physician

Name _____

Phone _____

Cardiologist

Name _____

Phone _____

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All Medication – Over the counter and prescription. DO NOT LEAVE BLANK.	Dose/MG	Surgical History – Type of Surgery	Date/Surgeon

Social History
Are you married? ❑Yes ❑No
Do you live with someone that can help you? ❑Yes ❑No
Do you smoke? ❑Yes ❑No Packs per day _____ ❑Former smoker - Date quit _____
Do you chew tobacco? ❑Yes ❑No ❑Have in the past - Date quit _____
Do you drink alcohol? ❑Yes ❑No Drinks per week _____
Any history of drug or alcohol abuse? ❑Yes ❑No

Family History: Check all that apply ❑ ADOPTED/UNKNOWN			
	SELF	MOTHER ❑DECEASED	FATHER ❑DECEASED
Heart Disease			
High Blood Pressure			
Stroke			
Cancer			
Diabetes			
Asthma			
Seizures			
Bleeding Disorder			
Thyroid Disease			
Kidney Disease			
Mental Illness			

CIRCLE ALL PROBLEMS YOU HAVE EXPERIENCED OR CIRCLE NORMAL IF NONE APPLY. READ EACH SECTION CAREFULLY.

CONSTITUTIONAL – Normal
Chills Fatigue Fever Malaise Night sweats Weakness
Unexpected weight gain Unexpected weight loss

HEENT – Normal
Dysphagia Ear drainage Headache Hearing loss
Ringing in ears Vision loss Glasses Contacts
Dentures Loose/Missing teeth

RESPIRATORY – Normal
Cough Recent infections Known TB exposure Wheezing
Bronchitis Pneumonia Shortness of breath

CARDIOVASCULAR – Normal
Chest pain Cyanosis Heart murmur Syncope
Irregular heartbeat Palpitations Pacemaker Stents
Heart attack High cholesterol

GASTROINTESTINAL – Normal
Abdominal pain Constipation Black/tarry stools Diarrhea
Jaundice Loss of appetite Nausea Vomiting Ulcer
Acid reflux Blood in stool

GENITOURINARY – Normal
Dysuria Frequent urination Hematuria (Blood in urine)
Urge incontinence Urinary incontinence Prostate disease

INTEGUMENTARY – Normal
Contact allergy Itchy skin Rash Skin infections Skin lesion

NEUROLOGICAL – Normal
Neuropathy Dizziness Poor coordination Tremors
Memory loss Muscle weakness Parasthesia

HEMATOLOGIC – Normal
Bleeding Bruising Anemia

PSYCHIATRIC – Normal
Anxiety Depression Insomnia Bipolar Schizophrenia

METABOLIC/ENDOCRINE – Normal
Cold intolerant Hair loss Heat intolerant

IMMUNOLOGICAL – Normal
Bee sting allergies Contact dermatitis
Environmental allergies Seasonal allergies

INFECTIOUS DISEASE – Normal
Hepatitis A/B/C HIV
History of MRSA? Yes____ OR No_____

MUSCULOSKELETAL – Normal
Rheumatoid arthritis Osteoarthritis Lupus
Joint pain Fibromyalgia