

PATIENT HISTORY
PRO SPORTS/PRO SPINE

Please Fill Out Completely.

Date: _____

Patient Name: _____ Age: _____ D.O.B. ____/____/____

Occupation: _____ Ht. _____ Wt. _____

Referring M.D. _____ Family M.D. _____

Current Medications: _____

Are you allergic to any medications? Yes _____ No _____ List: _____

Describe the problem(s) you are being seen for today: _____

Have you previously been treated for this problem? Yes _____ No _____ Where: _____

Pharmacy Name: _____ Location: _____

Are you Disabled? Yes _____ No _____ Work Related? Yes _____ No _____

Military? Yes _____ No _____ Lawsuit Involved? Yes _____ No _____

Were you seen in the Emergency Room? Yes _____ No _____

Have you had a recent Xray studies? Yes _____ No _____

PATIENT HISTORY	REVIEW OF SYSTEMS	SOCIAL HISTORY
Anemia _____	Prior Problem/risk _____	Married _____ Single _____ Divorced _____
Arthritis _____	of Anesthesia _____	Partnered _____ Widowed _____
Rheumatoid Arthritis _____	Diseases of Eyes,Nose _____	Number of Children Living? _____
Astma/Emphysema _____	Throat _____	Presently living alone? _____
Back Disorders _____	Sinusitis _____	Do you smoke? _____ Yes _____ No _____
Bursitis _____	Loss of Hearing _____	_____ Never
Bleeding Disorders _____	Indigestion,Heartburn _____	If no, when did you quit? _____
Cancer _____	Hiatal Hernia _____	Alcohol? _____ never _____ occasional
Where? _____	Peptic Ulcer/ _____	_____ moderate to heavy _____ family history
Diabetes _____	Stomach Pain _____	Drug overuse? _____ never _____ present
Heart Disease _____	Gallbladder Disease _____	_____ past problem
High Blood Pressure _____	Bowel Disease _____	
HIV (AIDS) _____	(i.e. Collitis,Diverticulitis) _____	PREVIOUS SURGERIES
Kidney Infection _____	Intestinal Bleeding _____	Tonsils _____
Lung Disease _____	Frequent Urination _____	Gallbladder _____
Lyme Disease _____	Burning on Urination _____	Appendix _____
Paralysis _____	Difficulty Starting _____	Prostate _____
Phlebitis _____	Urination _____	Hysterectomy/Ovaries _____
Pneumonia _____	Shortness of Breath _____	Cancer _____
Rheumatic Fever _____	Chills or Fever _____	Back/Disc. _____
Stroke _____	Heart/Chest Pain/ _____	Fracture _____
Thyroid Disease _____	Angina _____	Other _____
TB _____	Abnormal Heart Beat _____	List: _____
Other _____	Muscle Weakness _____	
	Joint Pain/Stiffness _____	
	Joint Swelling _____	
Seizures _____	Calf Cramps Walking _____	Major cause of death in family...
Mental Illness _____	Recent Welght Loss _____	Cancer _____
Leukemia _____	Leg/Skin Ulcers _____	Diabetes _____
	Mental Illness/Addiction _____	Heart Disease _____
	Gout _____	Hypertension _____
	Psoriasis _____	Accident _____

Reviewed with patient: _____

M.D.