

**Patient Health History Form**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle Int.: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_ ft \_\_\_\_ in Weight: \_\_\_\_\_ lbs.

(Please fill out the questionnaire completely so we may better care for your needs)

I was referred by:

- Lake Norman ER
- L.N.Urgent Care
- Lakeside Urgent Care
- My Doctor: \_\_\_\_\_
- Friend: \_\_\_\_\_
- Other: \_\_\_\_\_

What is the date your injury/symptoms started?

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  Exact date unknown

Approximately how long have you had this pain?

\_\_\_\_\_  Days  Months  Years

Who is your Primary Care Physician/Pediatrician?

\_\_\_\_\_

What is the main reason for your visit?

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

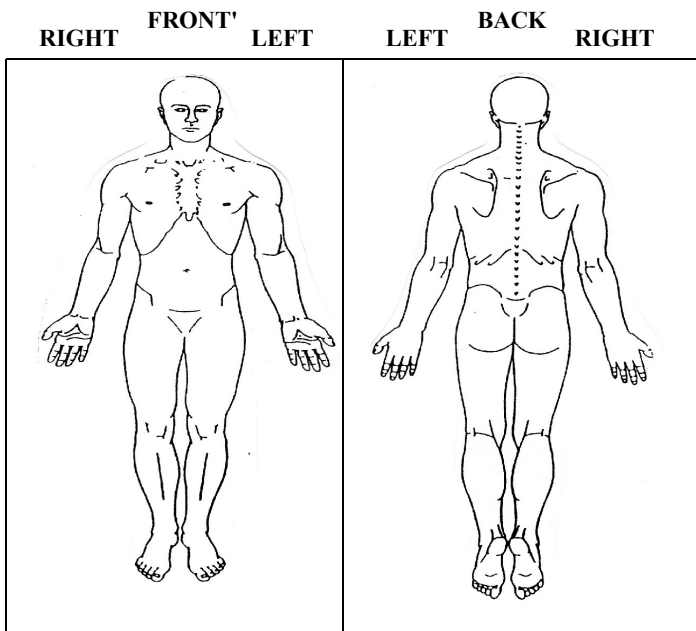
Where is your pain/injury located?

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

- Left  Right  Both

Is this a work related injury?  Yes  No

Please circle the area of your pain.



Describe how your injury occurred: (fall, basketball, football, soccer, etc...)

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

The pain is worse when I:

\_\_\_\_\_

The pain is better when I:

\_\_\_\_\_

I have had the following for this condition:

- Medication
- Physical Therapy
- MRI
- Surgery
- Injections
- X-rays
- CT
- EMG/ Nerve Conduction

Other treatments: \_\_\_\_\_  
\_\_\_\_\_

Please list all the doctors you have seen for this problem:

- Primary Care Physician
- Chiropractor
- Work Physician
- Other: \_\_\_\_\_
- ER Physician
- Trainer

Name: \_\_\_\_\_

Date of Visit: \_\_\_\_\_

Pain level on 1-10 scale: \_\_\_\_\_ (1=little to no pain, 10= worst)

Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Current Medications:**  I am taking no medications.

I take the following medications:  
(please include milligrams & how many per day)

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

I take the following supplements/herbal medications:

\_\_\_\_\_

Taking blood thinners?

Coumadin  Plavix  Aspirin  Lovenox

Dosage: \_\_\_\_\_

**Medical History:**  I have no medical problems

List your current medical conditions:

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

List any recent illnesses, injuries, hospitalizations or history of cancer: \_\_\_\_\_

\_\_\_\_\_

**Allergies:**  I have no known allergies

I am allergic to the following: \_\_\_\_\_

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

Has anyone in your family had problems with general anesthesia?  Yes  No

If yes, please explain:

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

The information above is correct to the best of my knowledge: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(patient, parent or guardian)

Completed By (please print): \_\_\_\_\_ Relationship: \_\_\_\_\_

*For Office Use Only*

Reviewed by: \_\_\_\_\_ M.D/P.A. Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
signature

**Family History:**

NONE

- |  |  |
|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes          |
| <input type="checkbox"/> Heart problems      | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Blood Clots         | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Cancer (type:)      | _____                                      |

List any major health problems with immediate family:  
(include diagnosis, age of onset & relationship)

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

**Surgical History:** (please list all surgeries)

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

**Social History:**

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

**Marital status:**  Single  Divorced  
 Married  Widowed  Separated

**Living Situation:**  w/Spouse  Alone  
 w/Family  Assisted Living

**Tobacco use:**  Never  Quit  No  Yes

If yes, how many packs daily? \_\_\_\_\_

How many years did you smoke? \_\_\_\_\_

If you quit, how long have you been smoke free?

\_\_\_\_\_  weeks  months  years

**Exercise:**  I do not exercise regularly  
 I exercise \_\_\_\_ hours per week

List types of exercise: \_\_\_\_\_

**Alcohol use:**  Never  Yes/Social

Type:  Wine  Beer  Liquor

Amount: \_\_\_\_\_ per week