



A Division of OSNA, PLLC

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PATIENT HISTORY FORM

Name _____ Age _____ Birthdate _____ Height _____ Weight _____

Consultation Requested By: _____

Are you: Right Handed Left Handed Male Female Occupation _____

Why are you here today? _____

When did the problem start? _____

How did it happen? _____

What makes it worse? _____

What makes it better? _____

For each, circle what **BEST** applies:

- The pain is: RARE INTERMITTENT CONSTANT
- The pain is: DULL SHARP ACHY THROBBING BURNING OTHER _____
- On a 0 to 10 severity scale (worst = 10) the pain is a: 0 1 2 3 4 5 6 7 8 9 10

Circle **ALL** that apply:

- Associated symptoms: CATCHING POPPING LOCKING GRINDING SWELLING STIFFNESS INSTABILITY WEAKNESS TINGLING NIGHT PAIN OTHER _____

Have you ever experienced any injury to or symptoms involving this body part in the past? Yes No

If so, please provide details: _____

Have you had any treatment for this problem? NONE Medication Therapy Splinting Injection Surgery

When: _____

Medical History: Do you currently or have you ever had any of the following? NONE

- | | | | | |
|--|--|---|--|---|
| <input type="checkbox"/> anemia | <input type="checkbox"/> arthritis | <input type="checkbox"/> asthma / COPD | <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> cancer | <input type="checkbox"/> chronic pain syndrome | <input type="checkbox"/> circulatory problems | <input type="checkbox"/> depression | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> drug / alcohol problems | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> gout | <input type="checkbox"/> heart disease | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> hypercholesterolemia | <input type="checkbox"/> kidney disease | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> psychiatric illness | <input type="checkbox"/> pregnancy (current) | <input type="checkbox"/> reflux / heartburn | <input type="checkbox"/> seizures | <input type="checkbox"/> sleep apnea / CPAP |
| <input type="checkbox"/> stomach ulcers | <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid problems | <input type="checkbox"/> other / details _____ | |

Medications: NONE additional sheet attached

| Medication (include over the counter medicines and nutritional supplements) | Reason Used | Dose |
|---|-------------|------|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

Medical Allergies (rash, swelling, or shortness of breath): NONE penicillin sulfa latex metals tape
 iodine (IV contrast) shellfish poultry products other _____

Medication Side Effects (heartburn, nausea, vomiting): NONE anti-inflammatories codeine Percocet
 Vicodin / Lortab other _____

Surgical History: NONE Circle **ALL** that apply:
 Eyes/ENT cataracts, vision correction, sleep apnea, tonsils, sinus surgery, thyroid, other _____
 Heart bypass, valve replacement, shunt, other _____
 Lung resection, other _____
 G I appendix, gall bladder, hernia, other _____
 Gynecologic c-section, hysterectomy, tubal ligation, other _____
 Urologic prostate, bladder, vasectomy, other _____
 Orthopaedic joint replacement, arthroscopy, fracture surgery, spine, other _____
 Vascular carotid, aneurysm, bypass, other _____
 Neurosurgical aneurysm, tumor, craniotomy, other _____
 Cancer skin, breast, prostate, colon, lung, other _____
 Other _____

Anesthesia Complications: NONE If yes, explain: _____

Other Current Symptoms Circle **ALL** that apply:
 Yes No Constitutional unexpected weight loss, weight gain, fever, chills, night sweats, fatigue _____
 Yes No Eyes blurred / double vision, eye pain, redness, watering _____
 Yes No ENT headache, difficulty swallowing, nose bleeds, ringing in the ears, earaches _____
 Yes No Cardiovascular chest pain, palpitations, fainting, murmurs _____
 Yes No Respiratory shortness of breath, wheezing, coughing, painful breathing, snoring _____
 Yes No Gastrointestinal heartburn, nausea, constipation, incontinence, diarrhea, bloody / black stool _____
 Yes No Musculoskeletal other joint pains, swelling, instability, stiffness, redness, heat, muscle pain _____
 Yes No Skin skin changes, poor healing, rash, itching, redness _____
 Yes No Neurological numbness / tingling, unsteady gait, dizziness, tremors, seizures _____
 Yes No Psychological nervousness, anxiety, depression, hallucinations _____
 Yes No Hematologic easy bleeding, bruising _____
 Yes No Endocrine excessive thirst or urination, heat / cold intolerance _____
 Yes No Allergic reaction to foods or environment _____
 Yes No Other _____

Family History (mother / father / siblings): NONE OF THE BELOW
 anesthesia complications _____ bleeding disorder _____
 cancer type _____ diabetes _____
 gout _____ heart disease _____
 malignant hyperthermia _____ arthritis _____
 other _____

Social History:
Marital Status: single married divorced widowed separated
Alcohol Use: none rare daily
Tobacco Use: none previous When quit? _____ current packs / day _____
Recreational Drug Use: none previous current drug _____ last used _____

Additional Information that you would like for us to know: _____

patient or responsible party signature _____ date _____

physician review _____ date _____ updated _____