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| **New Patient History Form** |



Using a black or blue pen, please write clearly and answer **ALL** questions by filling out the appropriate box(es).

|  |  |
| --- | --- |
| Name: | Today’s Date: |
| Date of Birth: | Gender (circle): Male Female Undifferentiated | Height: Weight: |
| Primary Care Provider: | Clinic/Location: |

**Current Medications/Supplements:**

\_\_\_\_\_\_\_ By initialing, I authorize Restoration Osteopathic Medicine to obtain my medication history from community pharmacies and/or pharmacy benefit managers for the purpose of continued treatment.

☐ **I am not taking any prescribed medications or over-the-counter supplements/vitamins.**

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| --- | --- | --- |
| **Medication** | **Dose** | **How many times per day?** |
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**Allergies:**

☐ **I have no known allergies to prescribed medications or medical supplies.**

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| --- | --- |
| **Medication** | **Reaction** |
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**Surgical History:**

Please list any previous surgeries. ☐ **NONE**

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| **Surgery** | **Date** |
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**Medical History:**

Please indicate whether you have or have had any of the following by filling in the appropriate box(es). ☐ **NONE**

|  |  |  |  |
| --- | --- | --- | --- |
| **General:**☐ COPD☐ High Blood Pressure☐ Diabetes☐ Myocardial Infarction (MI)☐ Stroke☐ Arthritis☐ Migraine☐ Asthma☐ Heart Failure (CHF)☐ Irregular Heartbeat**Allergy:**☐ Hay Fever☐ Other\_\_\_\_\_\_\_\_\_\_\_\_**Cancer:**☐ Skin (BCC, SCC or MM)☐ Prostate☐ Bladder☐ Thyroid☐ Bone☐ Lung☐ Colon | **Circulatory/Cardiovascular:**☐ Aneurysm☐ DVT☐ Pacemaker ☐ Atrial Fibrillation☐ Varicose Veins**Dermatologic:**☐ Eczema☐ Psoriasis**Digestive/Gastrointestinal:**☐ Gallbladder Disease☐ Liver Disease☐ Colitis☐ GERD☐ Hepatitis B or C (Circle)**Ears:**☐ Vertigo☐ Hearing Problem**Endocrine:**☐ Endocrine Disorder☐ Thyroid Disorder | **Genitourinary:**☐ Kidney Disease☐ Renal Dialysis☐ Kidney Infection☐ Renal Failure☐ Urinary Disorder**Hematologic:**☐ Anemia☐ Blood Disorder☐ Taking Blood Thinners**Infectious:**☐ Tuberculosis☐ Lyme Disease☐ HIV/AIDS**Musculoskeletal:** ☐ Artificial Joint ☐ Hip Fracture ☐ Osteoarthritis ☐ Knee Disorder ☐ Fracture Type: \_\_\_\_\_\_\_\_\_\_\_\_\_ | **Neurologic:**☐ Meningitis☐ TIA☐ Head Injury☐ Traumatic Brain Injury☐ Brain Disorder☐ Multiple Sclerosis**Psychologic:**☐ Anxiety☐ Depression☐ Emotional Abuse☐ Physical Abuse☐ Attempt Suicide☐ Psychiatric Disorder☐ Schizophrenia☐ Sexual Abuse**Respiratory:**☐ Sleep Apnea☐ Chronic Lung Disease☐ Other\_\_\_\_\_\_\_\_\_\_\_\_☐ Other\_\_\_\_\_\_\_\_\_\_\_\_☐ Other\_\_\_\_\_\_\_\_\_\_\_\_ |

**Review of Symptoms**

Please indicate whether you have or have had any of the following by filling in the appropriate box(es). ☐ **NONE**

|  |  |  |  |
| --- | --- | --- | --- |
| **General:**☐ Fatigue☐ Weight Gain☐ Weight Loss☐ Weakness**Musculoskeletal:**☐ Restricted motion☐ Muscle stiffness☐ Swelling ☐ Joint Pain ☐ Joint Stiffness | **Cardiovascular:**☐ Palpitations☐ Chest Pain☐ Swelling of Legs**Gastrointestinal:**☐ Abdominal Pain☐ Nausea☐ Diarrhea☐ Heartburn | **Psychiatric:**☐ Anxiety☐ Depression☐ Hallucinations☐ Insomnia☐ Nervousness**Neurological:**☐ Fainting☐ Tingling☐ Dizziness☐ Numbness | **Hematologic/Lymph:**☐ Easy Bruising☐ Easy Bleeding☐ Lumps☐ Blood Clots**Respiratory:**☐ Cough☐ Short of Breath☐ Wheezing |

**Family History:**  ☐ **NONE, Family members are all healthy.**

☐ **No Known Family History**

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| --- | --- | --- |
| **Family Member** | **Disease/Disorder** | **Alive or Deceased** |
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**Social History:**

|  |  |
| --- | --- |
| Occupation: |  |
| Employment Status: | ☐ Full-time ☐Part-time ☐ Retired ☐Unemployed ☐ Disabled ☐Homemaker  |
|  |  |
| Exercise: ☐ NONE | Type: Intensity: Duration: Frequency:☐ Flexibility ☐ Light ☐ 0-30 mins ☐ Daily ☐ Aerobic ☐ Moderate ☐ 31-60 mins ☐ Weekly  ☐ Vigorous ☐ 1- 1.5 hrs ☐ Monthly |
| Caffeine: ☐ NONE | Type: Cups (Daily):☐ Coffee ☐ Less than 1☐ Tea ☐ 1-2 ☐ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ 3-4  |
| Alcohol: ☐ NONE | Type: Frequency:☐ Beer ☐ Social ☐ Wine ☐ Light ☐ Liquor ☐ Occasional  |
| Smoking Status: | ☐ Current every day smoker ☐Current some day smoker ☐Light tobacco smoker ☐Heavy tobacco smoker ☐Former ☐Never |
| Nicotine products: | ☐ Cigars ☐Pipe ☐E-Cigarette ☐Chewing Tobacco ☐Former ☐Never |
| Drug use: | ☐Current- Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐Former- Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐Never  |

**Imaging:**

Please indicate if you have had any of the following imaging. ☐ **NONE**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type** | **Area of Body** | **Date** | **Facility** |
| Ultrasound |  |  |  |
| X-Ray |  |  |  |
| MRI Scan |  |  |  |

**Chief Complaint – Primary Reason for Today’s Visit:**

|  |  |
| --- | --- |
| Location of Pain: | Radiates? ☐ Yes ☐ No If so, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Date of Onset:  |
| Timing:  | ☐ Continuous ☐ Intermittent ☐ Changes in severity but always present | Started? ☐ Gradually ☐ Suddenly  |
| Cause: ☐ Accident ☐ Work Injury ☐ Surgery/Other If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Change over time:  | ☐ Improved☐ Worsened ☐ Stayed the Same |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Affects:**☐ Concentration☐ Work☐ Appetite☐ Sleep☐ Daily Activities ☐ Recreational Activities☐ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Improves With:**☐ Sitting☐ Walking☐ Standing☐ Exercise☐ Lying Down ☐ Heat/Ice☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_ | **Worsens With:**☐ Sitting☐ Walking☐ Standing☐ Exercise☐ Lying Down ☐ Heat/Ice☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_ | **Time of day pain is better:**☐ Morning ☐ Afternoon ☐ Evening ☐ Night☐ No specific time of day | **Time of day pain is worse:**☐ Morning ☐ Afternoon ☐ Evening ☐ Night☐ No specific time of day |

 **Pain Scale: Describe Your Pain:**

Please use as a reference to rate your pain level. **Pain Level:**  Please only check ones that apply.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Mild | Moderate | Severe |
| Sharp |  |  |  |
| Shooting |  |  |  |
| Cramping |  |  |  |
| Aching |  |  |  |
| Throbbing |  |  |  |
| Tender |  |  |  |
| Sore |  |  |  |
| Tingling |  |  |  |
| Numbing |  |  |  |
| Tiring |  |  |  |

|  |  |
| --- | --- |
| 0123 | No pain.You barely notice the pain.You may feel some twinges of pain.You notice the pain but can tolerate it. |
| 456 | You can ignore the pain at times.Can’t ignore the pain but still work through. Pain makes it hard to concentrate. |
| 78910 | Pain distracts you and limits your sleep.Pain is so intense you have trouble talking Pain is so bad you can’t even sleep or talk.Worst pain you can imagine. |

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| **Best:** |
| **Worst:** |
| **Currently:** |

**Treatments Tried:** ☐ **NONE**

|  |  |  |
| --- | --- | --- |
| **Type:** | **When/For How Long?** | **Any Relief?** |
| Physical Therapy |  |  |
| Chiropractic |  |  |
| Acupuncture |  |  |
| Injections |  |  |
| Massage |  |  |
| Medications (Example: Advil, Oxycodone, Flexeril, Prozac, Gabapentin, etc.) |  |  |