UT★ Physicians
A Part of UTHealth

MEDICAL HISTORY

Patient Name: ______________________ **Today's Date:** ______________

Age: ______ **Height:** ________ **Weight:** ________ **Are you?** Right handed Left handed Ambidextrous

Referring Doctor: ______________________ or **Referring Friend:** ______________

Other Physicians who are caring for you: ______________________

Describe your problem: ______________________

Have you had this problem in the past? Yes No **If yes, describe:** ______________

Duration of Symptom: ______________ or **Date of Injury:** ______________

Cause of Injury: ______________ **Is the injury work related?** Yes No N/A

Will there be any legal actions with respect to this problem? (circle one) Yes No Maybe

Are you represented by an attorney? Yes No **Name:** ______________

Seen in an ER for your presenting problem? Yes No **Location:** ______________ **Date:** ________

Rate your pain (circle one) No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

Do your symptoms wake you from your sleep? Yes No **Does your pain interfere with daily life activity?** Yes No

Describe your symptoms: sharp aching dull stabbing shooting burning throbbing

The pain (circle one) is constant comes and goes is only occasional morning evening

Since you made your appointment, is your problem getting better or worse? Getting better Getting worse Unchanged

What makes your pain worse? Squatting Kneeling Sitting Bending Stairs Twisting Moving Running

Lying in Bed Walking Athletics Standing Gripping Reaching Overhead Weight Bearing Activity Lifting

Are there any other symptoms associated to this problem? Redness Bruising Swelling Numbness Stiffness

Limping Clicking Locking Popping Tingling Weakness Giving Way

What relieves your symptoms? ______________________

You are able to walk (circle one) Unlimited >10 blocks 5-10 blocks < 5 blocks Housebound Unable

You use stairs by (circle one) Alternating Steps Up and Down Alternating Steps Up and Down with Railing

One Step at a Time without Railing One Step at a Time with Railing Unable to do stairs

Do you use one of the following? Cane Crutches Walker Wheelchair Brace **If so, for how long?** ________

You are able to tie your shoes or put on your socks (circle one) With ease With difficulty Unable

You are able to sit (circle one) In any chair 1 hour or greater In a high chair ½ hour or less Unable to sit ½ hour in any chair

You are able to rise from a chair (circle one) With ease (no arms) With ease (with arms) With difficulty Unable

Are you able to enter public transportation? Yes No

Studies already performed for this problem (circle all that apply) N/A x-rays CAT scan MRI nerve study bone scan

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Treatment so far (circle all that apply) None Anti-inflammatories Physical Therapy Injections Bracing

Activity Modification Home Exercises Rest Chiropractor Surgery Ice Heat

Your Own Personal Medical History (check all that apply to you)

___ Heart Attack ___ Stroke ___ Sleep Apnea ___ Hepatitis (A, B, C) ___ HIV

___ Pulmonary Embolus ___ TIA ___ Stomach Ulcers ___ High Blood Pressure ___ Congestive Heart Failure

___ Kidney Stones ___ Seizures ___ Phlebitis (blood clot) ___ Asthma/Emphysema ___ Cancer ___________

___ Kidney/Renal Failure ___ Pneumonia ___ Abnormal Bleeding ___ Depression/psychiatric disease ___________

___ Bladder Infections ___ Diabetes ___ Angina (chest pain) ___ Prior Infection ___________

Other: ___________

Are you experiencing any of the following symptoms? (circle all that apply)

None Fevers Night Sweats Loss of appetite Weakness Frequent Falls

Unintentional weight loss Loss of coordination Change in bowel or bladder habits Frequent Rashes

Do you have any metal in your body? Yes No **If yes, where?** ___________

Are you allergic to Metal? Yes No

Your Own Personal Medical History (continued)

List **all surgeries** you have had (include orthopedic surgeries)	Surgery dates

List all **allergies** to medications	List all **medication** you are **currently taking** (include over the counter medication)	

Are you taking blood thinners? Yes No If so, how long? ___________

Are you taking immunosuppressants? Yes No

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Family Medical History (describe conditions that run in your family)

Father: ______________________

Mother: ______________________

Sibling: ______________________

Social History

Occupation: ______________ **If retired, for how long?** ______________

Employer: ______________________

With whom do you live? ______________ **Marital Status:** Single Married Widowed

Do you smoke? Yes No **If so, how many packs per day?** ________ How long? ________

Other tobacco products? Yes No **If so, what and how often?** ______________

Did you quit using tobacco? Yes No **If so, when did you quit?** ______________

Do you use narcotics? Yes No **If so, what and how often?** ______________

Do you drink alcohol? Yes No **If so, how much?** ______________

Have you visited a dentist in the past twelve months? Yes No

How often do you brush your teeth? ____________ **Floss?** ____________

Do you have a history of any of the following? Broken teeth Tooth decay/infections Pulled teeth Root canal

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Pharmacy Information

Please list your pharmacy information for prescriptions and refills.

______________________ ______________________
Name **Location/Address**

______________ ______________
Phone Number **Fax Number**

______________________ ______________
Patient Signature **Date**

______________________ ______________
Provider Signature **Date**