Physician Associates – Dr. Marc Grossman

MEDICAL HISTORY INFORMATION

Name: _____ Date of Birth: ___/____/_____ Age: _____

Primary Care Physician _____ Referring Physician _____

What body part is involved? _____ O Right O Left O Bilateral

Date of Injury _____

Origin of Injury O Automobile O Workers' Compensation O Other _____

Rate the severity of pain on a scale of 0 – 10, with 10 being the worst pain ever felt. _____

Describe the pain. O Constant O Intermittent O Sharp O Dull O Burning O Shooting

What causes the pain? (Check all that apply.) O Sitting O Standing O Walking O Sleeping
O Bending O Lifting O Reaching O Stairs O Running O Other _____

Do you experience the following symptoms? (Check all that apply.) O Weakness O Numbness
O Tingling O Clicking O Instability O Catching O Swelling

What treatment have you had for this condition? (Check all that apply.)
O X-rays O MRI O EMG O Physical Therapy O Medication O Injection O Surgery O Other _____

_____

Drug Allergies: O None O Yes (Please list.) _____

Current Medications:

1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

Past Medical History: (Check all that apply.)

O Cancer	O Heart Disease	O Liver Disease	O Thyroid Disease
O Depression/Anxiety	O High Blood Pressure	O Lung Disease	O Ulcers
O Diabetes	O Kidney Disease	O Reflux	O Others _____

Past Surgical History:

Name	Year
1.	
2.	
3.	
4.	
5.	
6.	

Social History:

Do you smoke/chew tobacco products? O Currently everyday O Currently

O Never O Previously, Year Quit

Do you drink Alcohol? O Yes O No How often per week? _____

Do you take Illegal Drugs? O Yes O No

Do you exercise? O Yes O No O Cardiovascular How often per week? _____

O Strength training How often per week? _____

Family Medical History: (Please complete relevant information.)

	Sex	Living	Deceased	Diagnoses
Mother	F			
Father	M			
Sibling				
Sibling				
Other				

Review of Systems: Please check any symptoms you have recently experienced.

Constitutional: O Fever O Weightloss O Headache	Musculoskeletal: O Back pain O Neck Pain O Joint Pain
Eyes: O Worsening vision O Double vision	Neurologic: O Seizures O Tremors O Dizzy
Respiratory: O Shortness of Breath O Wheezing O Frequent Cough	Endocrine: O Excessive thirst O Temperature Sensitivity O Fatigue
Cardiovascular: O Chest Pain O Irregular Heartbeat O Leg swelling	Hematology/Lymphatic: O Swollen glands O Blood clotting problem
Immunological: O Drug Allergies	Skin: O Rash O Boils O Persistent itch
Gastrointestinal: O Nausea O Abdominal Pain O Indigestion/Heartburn	Urologic: O Urgency O Frequency O Hematuria O Pain
ENT: O Poor Hearing O Sinus problems O Sore throat	Psychological: O Depression O Anxiety

Patient Signature _____ Date _____

Doctor Signature _____ Date _____