

NEW PATIENT HEALTH HISTORY
Dr. Chris Reeves

Date of Visit _____

Name _____ DOB _____ Gender M F

Who referred you to Dr. Reeves? _____ Phone Number _____

Patient Phone Number: _____ Height _____ Weight _____

Hand Preference Right Left Are you pregnant? No Yes Unknown

Primary Care Provider _____ Phone _____

Preferred Pharmacy _____ Phone _____

Work Compensation Information Claim Number: _____ Date of Injury: _____

Employer: _____

Claims Adjuster: _____ Phone Number: _____ Fax: _____

Case Manager: _____ Phone Number: _____ Fax: _____

CHIEF COMPLAINT

Please describe your current injury/complaint. _____

How long have you experienced this condition? _____

What makes your symptoms better (ie, rest, medication)? _____

What makes your symptoms worse (ie, walking, bending)? _____

Which of your symptoms caused you the most concern? _____

Date of onset/injury _____ Were you in an auto accident? _____

Is this a work-related injury? YES NO Who is your case manager/case adjuster? _____

Have you had any x-rays or test performed for this condition?

YES (PLEASE BRING IMAGES ON DISC) NO

Type of test/scan _____

Date _____ Where was it done? _____

Type of test/scan _____

Date _____ Where was it done? _____

Type of test/scan _____

Date _____ Where was it done? _____

Have you had any prior treatment for this condition? YES NO

Describe _____

PAST MEDICAL HISTORY: Please check if you have now, or have had in the past, any of these medical conditions.

<input type="checkbox"/> NO PAST MEDICAL PROBLEMS	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Anemia	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Angina or Chest Pain	<input type="checkbox"/> Bleeding Ulcer	<input type="checkbox"/> Chronic Bronchitis
<input type="checkbox"/> Congestive Heart Failure/Heart Disease	<input type="checkbox"/> Headache/Migraines	<input type="checkbox"/> Blood Clot in Lung
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Liver Problems
<input type="checkbox"/> High Cholesterol/Triglycerides	<input type="checkbox"/> Emphysema (COPD)	<input type="checkbox"/> Diabetes- Insulin Non-Insulin

<input type="checkbox"/> Psychiatric history	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Kidney Stones / Disease
<input type="checkbox"/> Depression	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Urologic Problems
<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Stress Incontinence
<input type="checkbox"/> Blood Clot/DVT	<input type="checkbox"/> Reflux	<input type="checkbox"/> Enlarged Prostate
<input type="checkbox"/> <input type="checkbox"/> Legs <input type="checkbox"/> Lungs <input type="checkbox"/> Other	<input type="checkbox"/> Stomach or Intestinal Ulcer	<input type="checkbox"/> Frequent Urinary Inf (UTI)
<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Problems with Anesthesia
<input type="checkbox"/> Peripheral Neuropathy	<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Peptic Ulcer Disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Fracture(s) _____	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hepatitis __	<input type="checkbox"/> Intestinal Bleeding	<input type="checkbox"/> Other _____
<input type="checkbox"/> HiV+	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Comments _____

SURGICAL HISTORY: Please check if you have had any of these surgeries.

<input type="checkbox"/> NO PREVIOUS SURGERY	<input type="checkbox"/> Breast Surgery	<input type="checkbox"/> Prostate Surgery
<input type="checkbox"/> Abdominal Surgery	Type _____	<input type="checkbox"/> Other (explain)
Type: _____	<input type="checkbox"/> Carotid Surgery	_____
<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Colon Surgery	_____
<input type="checkbox"/> Angioplasty/Stents	<input type="checkbox"/> Coronary Bypass (CABG)	_____
<input type="checkbox"/> Artery Bypass of Arm or Leg	<input type="checkbox"/> Heart Valve Replacement	_____
<input type="checkbox"/> Bone/Joint Surgery	<input type="checkbox"/> Hysterectomy	_____
Type _____	<input type="checkbox"/> Pacemaker/Defibrillator	_____
<input type="checkbox"/> Back/Neck Surgery		
<input type="checkbox"/> Cervical (neck) Level(s) _____		When? _____
<input type="checkbox"/> Thoracic Level(s) _____		When? _____
<input type="checkbox"/> Lumbar (low back) Level(s) _____		When? _____
<input type="checkbox"/> Implanted Devices (If YES, check all that apply.)		
<input type="checkbox"/> Spinal Cord Stimulator	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> IUD
<input type="checkbox"/> Aneurysm Clip(s)	<input type="checkbox"/> AICD	<input type="checkbox"/> Breast Implant
<input type="checkbox"/> Intrathecal Pump	<input type="checkbox"/> Insulin Pump	<input type="checkbox"/> Venous Access
		<input type="checkbox"/> Screws, Pins, Plates
		Where? _____

MEDICATION ALLERGIES (PLEASE REVIEW/FILL OUT ATTACHED MEDICATION LIST)

<input type="checkbox"/> NO KNOWN MEDICATION ALLERGIES	
Are you allergic to Contrast Dye? <input type="checkbox"/> NO <input type="checkbox"/> YES	Reaction: _____
Are you allergic to Latex? <input type="checkbox"/> NO <input type="checkbox"/> YES	Reaction: _____
Are you allergic to Tape? <input type="checkbox"/> NO <input type="checkbox"/> YES	Type of tape or adhesive / reaction: _____
Are you allergic to any Food Items? <input type="checkbox"/> NO <input type="checkbox"/> YES	Type of food / reaction: _____
Medication Allergy: _____	Reaction: _____
Medication Allergy: _____	Reaction: _____
Medication Allergy: _____	Reaction: _____
Medication Allergy: _____	Reaction: _____
Medication Allergy: _____	Reaction: _____

FAMILY HISTORY:

Please check below if any immediate relatives have had any of these conditions: **F**–father, **M**–mother, **S**–sibling.

Adopted

<input type="checkbox"/> NO FAMILY HISTORY TO REPORT	<input type="checkbox"/> Cancer	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Psychiatric Disease
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Other (Explain)
<input type="checkbox"/> Anesthesia Difficulties	<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Rheumatoid Arthritis	_____
<input type="checkbox"/> Other Inherited Disease (type)		_____

Patient Name _____ DOB _____ Date of Visit _____

SOCIAL HISTORY:

Occupation																	
Work Demands	<input type="checkbox"/>	Sedentary				<input type="checkbox"/>	Moderately Active			<input type="checkbox"/>	Heavy Labor						
Work Status	<input type="checkbox"/>	Working		<input type="checkbox"/>	Retired		<input type="checkbox"/>	Disabled			<input type="checkbox"/>	Other					
Education Level	<input type="checkbox"/>	Grade School			<input type="checkbox"/>	High School			<input type="checkbox"/>	Technical School		<input type="checkbox"/>	Associated Degree				
	<input type="checkbox"/>	Bachelor's Degree			<input type="checkbox"/>	Master's Degree			<input type="checkbox"/>	Doctorate							
Marital Status	<input type="checkbox"/>	Single			<input type="checkbox"/>	Married			<input type="checkbox"/>	Partner		<input type="checkbox"/>	Divorced		<input type="checkbox"/>	Widow/Widower	
Smoking	<input type="checkbox"/>	Never Smoked						<input type="checkbox"/>	Former Smoker			Quit Date: _____					
Are you a current smoker?				<input type="checkbox"/>	No		<input type="checkbox"/>	Yes		How many packs per day? _____							
Do you dip or chew tobacco?				<input type="checkbox"/>	No		<input type="checkbox"/>	Yes		How much per day? _____							
Do you drink alcoholic beverages?				<input type="checkbox"/>	No		<input type="checkbox"/>	Yes		How many drinks per week? _____							
Do you use recreational drugs?				<input type="checkbox"/>	No		<input type="checkbox"/>	Yes		What and how often? _____							
Have you injected illegal drugs?				<input type="checkbox"/>	No		<input type="checkbox"/>	Yes		What and how often? _____							
Do exercise regularly?				<input type="checkbox"/>	No		<input type="checkbox"/>	Yes		Describe _____							
What sports/activities do you participate in?																	

REVIEW OF SYSTEMS: Please check if you have now, or recently experienced any of these medical conditions.

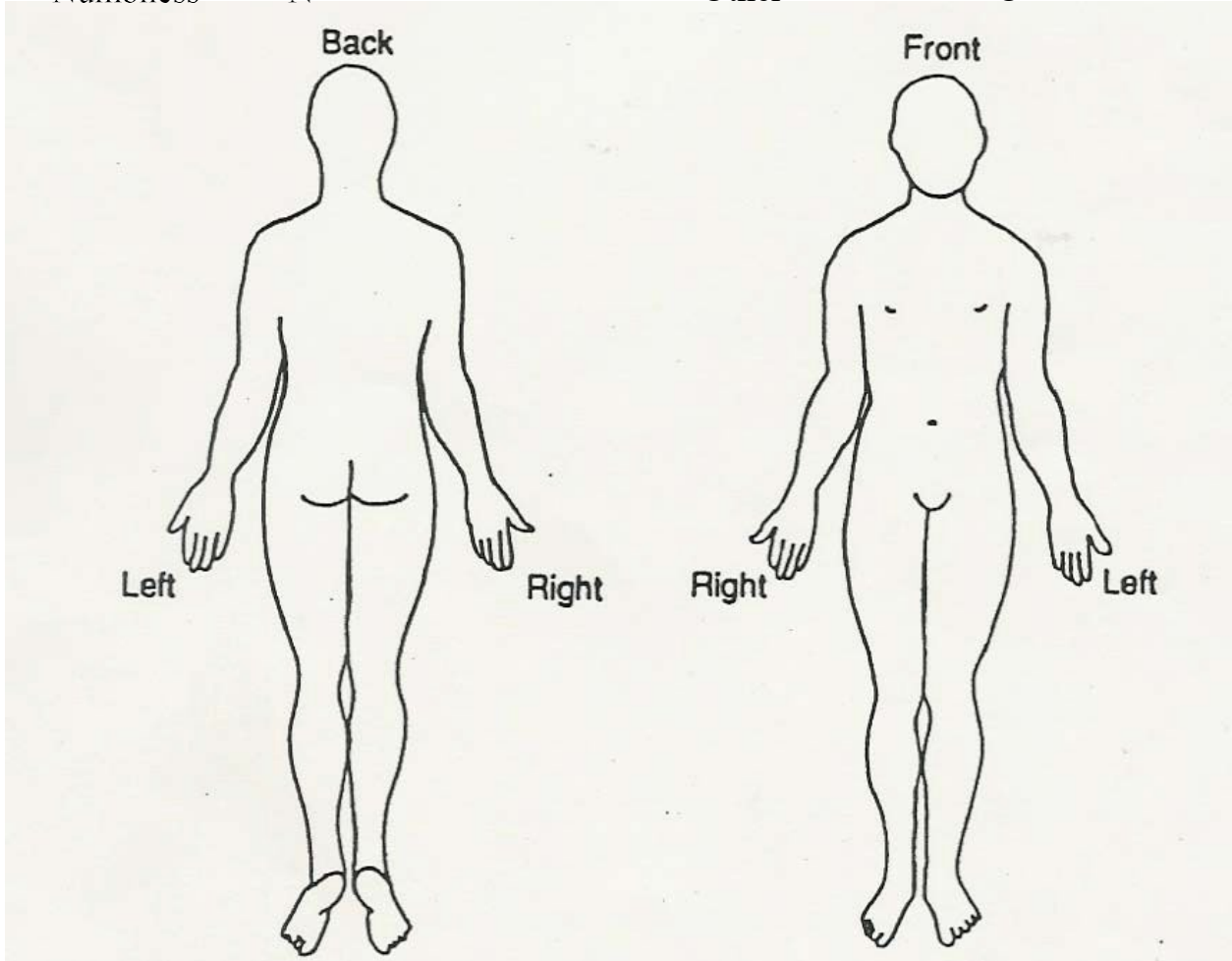
<input type="checkbox"/>	Good General Health	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Dry Skin / Itching
<input type="checkbox"/>	Recent Weight Gain / Loss	<input type="checkbox"/>	Spitting up Blood	<input type="checkbox"/>	Chronic Skin Ulcers
<input type="checkbox"/>	Fever/Chills/Night Sweats	<input type="checkbox"/>	Change in Bowel Habits	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	Numbness / Tingling
<input type="checkbox"/>	Eye Disease/Injury	<input type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	Blackouts
<input type="checkbox"/>	Wear Glasses / Contacts	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Tremors
<input type="checkbox"/>	Blurred / Double Vision	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	Hearing Loss / Ringing	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Chronic Sinus Problem	<input type="checkbox"/>	Burning / Painful Urination	<input type="checkbox"/>	Memory Loss or Confusion
<input type="checkbox"/>	Nosebleed	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	Slow Healing after Cuts
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Bruising Tendency
<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Difficulty Walking	<input type="checkbox"/>	Transfusions
<input type="checkbox"/>	Faintness	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	Breathing Problems	<input type="checkbox"/>	Leg Cramps	<input type="checkbox"/>	Excessive Sweating
<input type="checkbox"/>	Chronic / Frequent Coughs	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	Other _____

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PAIN DIAGRAM

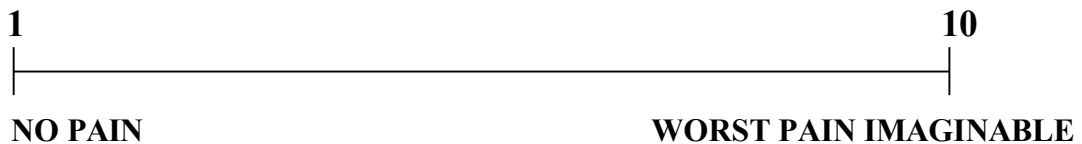
Please use the symbols below to show the area, upon the body outlines, in which you are experiencing pain.

- | | |
|---------------------------|-------------------------|
| Ache- A | Pins and Needles P |
| Burning- B | Stabbing S |
| Numbness- N | Other- O |



The line below represents the intensity of the pain you are experiencing. Please make an "X" at the position on the scale which indicates how much pain you are feeling *at this time*.

Date _____



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Patient Name _____ DOB _____ Date of Visit _____

Patient Medication List

Please list ALL medications (including prescription, over the counter, vitamins, dietary or nutritional supplements) which you may be taking routinely and/or on an as needed basis.

MEDICATION	DOSAGE	FREQUENCY	HOW TAKEN

I understand the need to inform Dr. Reeves of any changes in my medical condition. To the best of my knowledge, the information provided on this form is correct and accurate.

Signature of Patient / Legal Guardian

Date

Patient Name _____ DOB _____ Date of Visit _____