

Patient Name: _____

Date: _____

Form: PHX



Medical disorders: If you have had any of the following, Place Mark inside Circles

- | | | |
|--|---|---|
| <input type="radio"/> No Medical History | <input type="radio"/> Stroke | <input type="radio"/> Sleep Apnea |
| <input type="radio"/> AIDS/HIV | <input type="radio"/> Cancer Breast | <input type="radio"/> Gout |
| <input type="radio"/> Alcoholism | <input type="radio"/> Cancer Colon | <input type="radio"/> Heart Attack |
| <input type="radio"/> Alzheimer's | <input type="radio"/> Cancer Lung | <input type="radio"/> High Blood Pressure |
| <input type="radio"/> Anemia | <input type="radio"/> Cancer Prostate | <input type="radio"/> Hepatitis |
| <input type="radio"/> Rheumatoid Arthritis | <input type="radio"/> COPD | <input type="radio"/> Kidney Disease |
| <input type="radio"/> Asthma | <input type="radio"/> Depression | <input type="radio"/> Osteoarthritis |
| <input type="radio"/> Blood Clot Leg | <input type="radio"/> Diabetes | <input type="radio"/> Seizures |
| <input type="radio"/> Blood Clot Lung | <input type="radio"/> Drug Abuse | <input type="radio"/> Ulcers, Bleeding |
| <input type="radio"/> Other Disease (list below) | <input type="radio"/> Blood thinners (Coumadin, Plavix, aspirin, etc) | |

Surgical History: If you have had any of the following, Place Mark inside Circles

- | | |
|---|--|
| <input type="radio"/> No Surgical History Reported | <input type="radio"/> Cardiac (Heart) |
| <input type="radio"/> Carpal Tunnel Left Wrist | <input type="radio"/> Carpal Tunnel Right Wrist |
| <input type="radio"/> Arthroscopy Left Elbow | <input type="radio"/> Arthroscopy Right Elbow |
| <input type="radio"/> Arthroscopy Left Shoulder | <input type="radio"/> Arthroscopy Right Shoulder |
| <input type="radio"/> Arthroscopy Left Ankle | <input type="radio"/> Arthroscopy Right Ankle |
| <input type="radio"/> Arthroscopy Left Knee | <input type="radio"/> Arthroscopy Right Knee |
| <input type="radio"/> Arthroscopy Left Hip | <input type="radio"/> Arthroscopy Right Hip |
| <input type="radio"/> Left Hip Replacement | <input type="radio"/> Right Hip Replacement |
| <input type="radio"/> Left Knee Replacement | <input type="radio"/> Right Knee Replacement |
| <input type="radio"/> Spinal Fusion | <input type="radio"/> Laminectomy |
| <input type="radio"/> Other Surgery (list in the box below) | <input type="radio"/> Fracture Surgery |

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Family History:

If any family Member below has any of the following history, Place Mark inside Circles

Father Medical History

- | | | |
|---|------------------------------------|--|
| <input type="radio"/> AIDS/HIV | <input type="radio"/> Diabetes | <input type="radio"/> Kidney Disease |
| <input type="radio"/> Anemia | <input type="radio"/> Gout | <input type="radio"/> Liver Disease |
| <input type="radio"/> Blood Clots | <input type="radio"/> Heart Attack | <input type="radio"/> Muscle Disease |
| <input type="radio"/> Cancer | <input type="radio"/> Hemophilia | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Coronary Artery Disease | <input type="radio"/> Hypertension | <input type="radio"/> Rheumatoid Arthritis |
| | | <input type="radio"/> Osteoarthritis |

Mother Medical History

- | | | |
|---|------------------------------------|--|
| <input type="radio"/> AIDS/HIV | <input type="radio"/> Diabetes | <input type="radio"/> Kidney Disease |
| <input type="radio"/> Anemia | <input type="radio"/> Gout | <input type="radio"/> Liver Disease |
| <input type="radio"/> Blood Clots | <input type="radio"/> Heart Attack | <input type="radio"/> Muscle Disease |
| <input type="radio"/> Cancer | <input type="radio"/> Hemophilia | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Coronary Artery Disease | <input type="radio"/> Hypertension | <input type="radio"/> Rheumatoid Arthritis |
| | | <input type="radio"/> Osteoarthritis |

Sibling Medical History

- | | | |
|---|------------------------------------|--|
| <input type="radio"/> AIDS/HIV | <input type="radio"/> Diabetes | <input type="radio"/> Kidney Disease |
| <input type="radio"/> Anemia | <input type="radio"/> Gout | <input type="radio"/> Liver Disease |
| <input type="radio"/> Blood Clots | <input type="radio"/> Heart Attack | <input type="radio"/> Muscle Disease |
| <input type="radio"/> Cancer | <input type="radio"/> Hemophilia | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Coronary Artery Disease | <input type="radio"/> Hypertension | <input type="radio"/> Rheumatoid Arthritis |
| | | <input type="radio"/> Osteoarthritis |

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Review of Systems: If you have any of the following, Please Place Mark inside Circles

Constitutional

- Weight Loss/Gain
- Weakness
- Fatigue
- Fever

Cardiovascular

- High Blood Pressure
- Chest Pain
- Rheumatic Fever
- Palpitations
- Has Pacemaker

Musculoskeletal

- Joint Pain
- Arthritis
- Muscular Weakness
- Stiffness
- Muscular Pain

Eyes

- Glasses or Contacts
- Blurred Vision
- Glaucoma
- Cataracts
- Excessive Tearing

Skin

- Rashes
- Sores
- Lumps
- Dryness
- Itching

Blood or Lymph

- Anemia
- Easy Bruising
- Easy Bleeding
- Swollen Glands

Ear Nose Mouth Throat:

- Ears Ringing
- Earaches
- Hearing Aid
- Frequent Colds
- Nasal Discharge
- Hay Fever
- Nosebleeds
- Dentures
- Bleeding Gums
- Frequent Sore throats

Neurological

- Headache
- Dizziness
- Seizures
- Loss of Sensation
- Vertigo

Respiratory

- Shortness of Breath
- Cough
- Wheezing
- Asthma
- Bronchitis

Gastrointestinal

- Heart Burn
- Rectal Bleeding
- Abdominal Pain
- Gallbladder trouble
- Hepatitis

Genitourinary

- Blood in Urine
- Urinary Infections
- Kidney Stones
- Burning Urination
- Sexual Disease

Endocrine

- Thyroid Trouble
- Excessive Sweating
- Excessive thirst

Immunologic

- Reactions to Drugs
- Skin Rashes
- Reactions to Foods

Psychological

- Nervousness
- Depression
- Mood Changes

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Social History: Please respond to the following by Placing Mark inside Circles

Substance Use:

Do you:

Use Tobacco? Yes No Former

Use Alcohol? Yes No

Use Caffeine? Yes No

Use Illicit Drugs? Yes No

I do not use any of the above

Hand Dominance? Right Handed Left Handed

Females Only:

Could you be pregnant? Yes No

Allergies: Do you have allergies to any of the following medications or substances

- | | | |
|--|--------------------------------|---------------------------------|
| <input type="radio"/> No Known Allergies | <input type="radio"/> Aspirin | |
| <input type="radio"/> Penicillin | <input type="radio"/> Amoxil | <input type="radio"/> Tegretol |
| <input type="radio"/> Codeines | <input type="radio"/> Keflex | <input type="radio"/> Bactrim |
| <input type="radio"/> Sulpha Drugs | <input type="radio"/> Cefzil | <input type="radio"/> Pediazole |
| <input type="radio"/> Iodine / Shellfish | <input type="radio"/> Ceftin | <input type="radio"/> Dilantin |
| <input type="radio"/> Ampicillin | <input type="radio"/> Suprax | <input type="radio"/> Novacaine |
| <input type="radio"/> Vantin | <input type="radio"/> Septra | <input type="radio"/> Insulin |
| <input type="radio"/> Depakene | <input type="radio"/> Lamictal | <input type="radio"/> Lidocaine |

Other Allergies:

- Latex IVP/X-Ray Dye Metal Egg/Avian (Bird)

List any other allergies in this box