POTOMAC PHYSICAL MEDICINE

PATIENT HEALTH HISTORY

Please review and complete the following carefully.

CONFIDENTIAL PATIENT INFORMATION							
Last Name:				**Date of Birth:** *MM/DY/YEAR*		**Age:**	
First Name:		**M.I.:**		**Sex:**	☐ Male ☐ Female		

WHAT IS YOUR MAIN HEALTH CONCERN AND REASON FOR YOUR VISIT TODAY?

ALLERGIES ☐ Yes ☐ No *(IF YES, PLEASE LIST)*

1:	
2:	
3:	
4:	
5:	
6:	

MEDICATIONS ☐ Yes ☐ No *(IF YES, PLEASE LIST PRESCRIPTIONS, NON-PRESCRIPTION MEDICINES, SUPPLEMENTS, & HOME REMEDIES)*

Medication:	Dose:	Times per Day:	Medication:	Dose:	Times per Day:
1.			**6.**		
2.			**7.**		
3.			**8.**		
4.			**9.**		
5.			**10.**		

SURGICAL HISTORY ☐ Yes ☐ No *(IF YES, PLEASE LIST SURGICAL INTERVENTIONS, WHICH MAY OR MANY NOT HAVE INCLUDED HOSPITLIZATION)*

Procedure:	Year:	Reason:

SOCIAL HABITS AN

Cigarettes/Tobacco use: ☐ Yes ☐ No	Alcohol use: ☐ Yes ☐ No	Recreational Drug Use: ☐ Yes ☐ No
Pack per Day _____ For how long _____ Quit Date _____	Type _____ Amount _____ How Often _____	Type _____ Amount _____ How Often _____

NUTRITION & DIET

How do you best describe your diet? (may select more than one)	☐ Healthy ☐ Moderately Healthy ☐ Poor	☐ Primarily Take-Out Meals ☐ Primarily Home-Cook Meals	☐ Other *(PLEASE COMMENT):*
Your diet is best defined as:	☐ Regular/Average ☐ Vegetarian	☐ Paleo ☐ Vegan	☐ Other *(PLEASE COMMENT):*
How many meals do you usually eat daily?	☐ Skip breakfast ☐ Two meals per day	☐ Three meals per day ☐ Over four meals per day	☐ Snack in between meals

Coffee/Caffeine use: ☐ Yes ☐ No If yes, # of cups/ounces per day?	Soda Consumption: ☐ Yes ☐ No If yes, # of cups/ounces per day?	Water Consumption: ☐ Yes ☐ No If yes, # of cups/ounces per day?

EXERCISE

How do you best describe your lifestyle? (select one)

☐ Sedentary (No exercise)
☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Do you do mobility before and/or after exercise? ☐ Yes ☐ No *IF YES, PLEASE LIST WHAT YOU DO*	Do you have pain or discomfort with exercise, stretching, or mobility? ☐ Yes ☐ No *IF YES, PLEASE CLARIFY*

WOMEN ONLY

Are you pregnant?	☐ Yes ☐ No ☐ Unsure	Last Colonoscopy:	☐ Normal ☐ Abnormal
Are you breastfeeding?	☐ Yes ☐ No	Last Mammogram:	☐ Normal ☐ Abnormal
Last menstrual period:		Hormone Replacement Therapy:	☐ Yes ☐ No
Last Pap:	☐ Normal ☐ Abnormal	Age of Menopause:	
Abnormal Vaginal Bleeding:	☐ Yes ☐ No	History of STDs (check all that apply)	☐ Herpes ☐ Chlamydia ☐ HPV ☐ Gonorrhea ☐ Syphilis
Cramps:	☐ No ☐ Moderate ☐ Mild ☐ Severe		
How many: Pregnancies _____ Abortions _____ Deliveries _____ Miscarriages _____		Infections? (check all that apply)	☐ Yeast ☐ Bacterial Vaginosis ☐ PID ☐ Discharge

Other *(PLEASE COMMENT):*

MEN ONLY

Vasectomy: ☐ No ☐ Yes If yes, when?		Penile Discharge or pain:	☐ Yes ☐ No
Date of Last Prostate Exam:		Testicular Lumps:	☐ Yes ☐ No
Date of Last PSA:		Erectile Dysfunction:	☐ Yes ☐ No
Last Colonoscopy:	☐ Normal ☐ Abnormal	History of STDs (check all that apply)	☐ Syphilis ☐ Chlamydia ☐ Herpes ☐ Gonorrhea ☐ HPV

Other *(PLEASE COMMENT):*

MEDICAL HISTORY

Alcoholism	☐ Had ☐ Have	Headaches/Migraines	☐ Had ☐ Have	Osteoporosis/Osteopenia	☐ Had ☐ Have
Aneurysm	☐ Had ☐ Have	Heart Attack/Disease	☐ Had ☐ Have	Pacemaker	☐ Had ☐ Have
Anorexia	☐ Had ☐ Have	Hepatitis/Liver	☐ Had ☐ Have	Polio	☐ Had ☐ Have
Arthritis	☐ Had ☐ Have	Hiatal Hernia	☐ Had ☐ Have	Psychiatric Disorders	☐ Had ☐ Have
Asthma	☐ Had ☐ Have	High Blood Pressure	☐ Had ☐ Have	Rheumatoid Arthritis	☐ Had ☐ Have
Back/Neck Problems	☐ Had ☐ Have	High Cholesterol	☐ Had ☐ Have	Sciatica	☐ Had ☐ Have
Cancer	☐ Had ☐ Have	Incontinence	☐ Had ☐ Have	Skin Disorders	☐ Had ☐ Have
Carpal Tunnel	☐ Had ☐ Have	Insomnia	☐ Had ☐ Have	Stroke	☐ Had ☐ Have
Depression/Anxiety	☐ Had ☐ Have	Irritable Bowel Syndrome	☐ Had ☐ Have	Thyroid Dysfunction	☐ Had ☐ Have
Diabetes	☐ Had ☐ Have	Joint Problems	☐ Had ☐ Have	Tuberculosis	☐ Had ☐ Have
Emphysema	☐ Had ☐ Have	Kidney Disease	☐ Had ☐ Have	Vision/Hearing Loss	☐ Had ☐ Have
Epilepsy/ Neurological issues	☐ Had ☐ Have	Multiple Sclerosis	☐ Had ☐ Have	Other *(PLEASE COMMENT):*	☐ Had ☐ Have
Fractures/Broken Bones	☐ Had ☐ Have	Neuropathy	☐ Had ☐ Have		
Gallbladder Issues	☐ Had ☐ Have	Obesity	☐ Had ☐ Have		

REVIEW OF SYSTEMS *(CHECK ALL THAT APPLY)*

Constitutional:	☐ Weight Loss/Gain ☐ Fever or Chills ☐ Fatigue	☐ Trouble Sleeping ☐ Other	Urinary:	☐ Frequency ☐ Urgency ☐ Burning or pain	☐ Blood in urine ☐ Incontinence ☐ Other
Abdomen/Gastro:	☐ Pain ☐ Bloating ☐ Blood in stool ☐ Poor appetite	☐ Diarrhea ☐ Constipation ☐ Nausea ☐ Other	Head & Neck:	☐ Pain/Headaches ☐ Lumps ☐ Blurry Vision ☐ Swollen glands	☐ Stiffness ☐ Decreased Hearing ☐ Other
Cardiovascular:	☐ Rapid Heart rate ☐ Irregular Heart Beat ☐ Chest pain	☐ Shortness of breath ☐ Other	Respiratory:	☐ Cough ☐ Difficulty breathing ☐ Wheezing	☐ Painful breathing ☐ Other
Breast	☐ Lumps ☐ Discharge ☐ Breast-feeding	☐ Pain ☐ Self-Exams ☐ Other	Skin:	☐ Rashes ☐ Itching/Dryness ☐ Color Changes	☐ Lumps ☐ Hair and nail ☐ changes Other
Musculoskeletal:	☐ Muscle or joint pain ☐ Stiffness ☐ Back pain	☐ Swelling of Joints ☐ Muscle cramps ☐ Other	Neurological:	☐ Dizziness ☐ Headaches Fainting ☐ Seizures	☐ Numbness/Tingling ☐ Weakness ☐ Other
Psychiatric:	☐ Insomnia ☐ Depression ☐ Anxiety ☐ Mood Swings	☐ Memory Loss ☐ Nervousness ☐ Other	Other *(PLEASE COMMENT):*		

REVIEW OF PAIN

Pain Onset. *WHEN DID YOU FIRST NOTICE SYMPTOMS?*	Does your pain wake you up at night? *(PLEASE COMMENT):* ☐ Yes ☐ No
How often do you experience your symptoms? ☐ Constantly *(76-100% OF THE DAY)* ☐ Frequently *(51-75% OF THE DAY* ☐ Occasionally *(26-50% OF THE DAY)* ☐ Intermittently *(0-25% OF THE DAY)*	How would you describe your pain? ☐ Sharp/Shooting ☐ Numb ☐ Stiff ☐ Burning ☐ Throbbing ☐ Burning ☐ Dull ☐ Tingling ☐ Other

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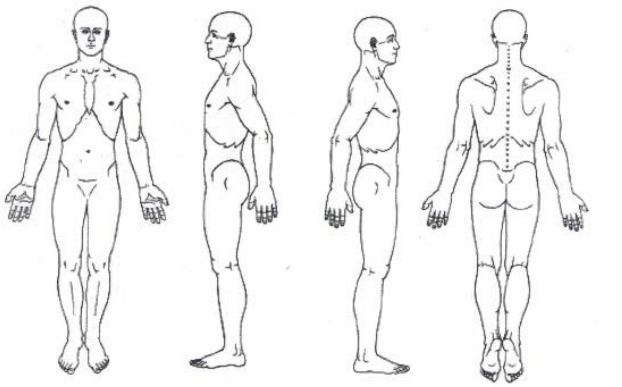
Using the symbols below, mark on the pictures where you feel pain. For example, if the right side of your neck hurts, mark the drawing on the right side of the neck. Please indicate which sensations you feel by referring to the key below.

KEY

///// STABBING | XXXX BURNING | 0000 PINS & NEEDLES | ==== NUMBNESS | ++++ ACHING



AVERAGE PAIN INTENSITY

CIRCLE ONE PER ROW

Last 24 hours:	no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain
Past week:	no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain

Prior Interventions: *CHECK ALL THAT APPLY*

- ☐ Prescription Medications ☐ Other:
- ☐ Over the Counter Drugs
- ☐ Homeopathic Remedies
- ☐ Physical Therapy
- ☐ Acupuncture
- ☐ Massage
- ☐ Surgery
- ☐ Ice/ Heat
- ☐ Yoga/Mobility _____

Pain is the result of: *CHECK ALL THAT APPLY*

- ☐ Accident or Injury. *IF SELECTED PLEASE CLARIFY*
  - ☐ Work ☐ Auto ☐ Other_____
- ☐ Worsening Long-term Problem/ Chronic
- ☐ Chronic Problem
- ☐ Other *PLEASE COMMENT*

How does your current condition interfere with the following:

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying down	☐	☐	☐	☐
Bending over	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	☐	☐	☐	☐
Household chores	☐	☐	☐	☐
Lifting objects	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Showering or bathing	☐	☐	☐	☐
Dressing myself	☐	☐	☐	☐
Love life	☐	☐	☐	☐
Getting to sleep	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Yard work	☐	☐	☐	☐

What is the biggest physical limitation you have due to this injury?

I hereby attest that the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern(s).

Patient Name or Legal Representative: *PRINT*		**Date of Birth:** *MM/DY/YEAR*	
Signature:		**Date:** *MM/DY/YEAR*	