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UT★Physicians
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Patient Information

Patient Name: _____ Date of visit: _____

Date of Birth: _____ Age: _____ Sex: M / F Height: _____ Weight: _____

Referred by: _____ Primary Care Physician: _____

Chief Complaint E-mail address (optional): _____

Describe the problem you are having in your own words: _____

_____

Which side is affected? RIGHT / LEFT / BOTH

When did this problem first occur (or date of injury): _____

If this was an injury, what happened: _____

Is this injury: ☐ work related ☐ workers compensation ☐ the subject of a lawsuit you are filing

Have you seen another physician for this problem: ☐ No ☐ Yes (name) _____

***** if you have outside x-rays or MRI, please bring the CD with you to your visit**

Have you had any prior treatment for this problem (brace/splint, medications, injections, therapy, surgery):

_____

Current level of pain (0 = no pain, 10 = worst pain of my life): _____

Type of pain: ☐ aching ☐ burning ☐ dull ☐ throbbing ☐ tingling ☐ shooting

What makes the problem worse: ☐ heavy lifting ☐ overhead reaching ☐ keyboard use ☐ sports

☐ opening jars ☐ opening doors ☐ other _____

What makes the problem better: ☐ brace ☐ ice ☐ heat ☐ rest ☐ medications ☐ other _____

Review of Systems (please check any symptoms you have had recently)

Constitutional	☐ Fevers	☐ Chills	☐ Night sweats
Eyes	☐ Vision loss	☐ Blurred vision	☐ Double vision
Ears/Nose/Throat	☐ Hearing loss	☐ Ringing in ears	☐ Sore throat
Cardiovascular	☐ Chest pain	☐ Heart palpitations	☐ Irregular heartbeat
Respiratory	☐ Shortness of breath	☐ Cough	☐ Wheezing
Gastrointestinal	☐ Nausea/vomiting	☐ Diarrhea	☐ Blood in stool
Genitourinary	☐ Urinary pain	☐ Blood in urine	
Musculoskeletal	☐ Back pain	☐ Leg pain	☐ Muscle spasms
Integumentary	☐ Skin rashes	☐ Hives	☐ Skin cancer
Neurological	☐ Headache	☐ Tremors	☐ Passing out
Endocrine	☐ Hot/cold intolerance	☐ Frequent urination	☐ Excessive thirst
Heme/Lymph	☐ Anemia	☐ Excessive bleeding	

Past Medical History (please check all that apply)

☐ High blood pressure
☐ Atrial fibrillation
☐ Emphysema/COPD
☐ Gastric reflux
☐ Diabetes
☐ Heavy bleeding/anemia
☐ Osteoporosis
☐ Rheumatoid arthritis
☐ Hepatitis C
☐ Currently pregnant
☐ Heart Attack (date _____)
☐ Cardiac Stents (date _____)
☐ Asthma
☐ Stomach ulcer/bleeding
☐ Kidney problems/dialysis
☐ Stroke (date _____)
☐ Depression
☐ Lupus, scleroderma, etc.
☐ HIV positive
☐ Cancer _____
☐ High cholesterol
☐ Peripheral vascular disease
☐ Blood clots/DVT/PE
☐ Bowel disorder: _____
☐ Hypothyroid
☐ Seizures
☐ Anxiety
☐ Gout
☐ Sleep apnea

Past Surgical History (please list all surgeries including date and body part)

_____

Allergies _____

Family History Any family history of heart problems, bleeding problems, or blood clots in immediate family members? If so, please describe _____

Social History Occupation: _____ ☐ Disabled ☐ Retired

Which hand do you write with? ☐ Right ☐ Left

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Alcohol use: ☐ Never ☐ Socially ☐ Weekends ☐ Daily

Do you smoke: ☐ No ☐ Yes _____ packs per day

Educational level: ☐ High School ☐ College ☐ Professional/Graduate ☐ Trade

Sports: ☐ golf ☐ tennis ☐ soccer ☐ football ☐ baseball ☐ basketball ☐ gymnastics ☐ bowling

Hobbies: _____

Do you have numbness or tingling in your hands? ☐ Yes ☐ No

If so, does it wake you up at night? ☐ Yes ☐ No How many nights per week? _____

Have you ever had a nerve conduction study? ☐ Yes ☐ No

Do you have diabetes or high blood sugar? ☐ Yes ☐ No

If so, how is it treated? ☐ Diet only ☐ Oral medications (pills) ☐ Insulin

Do you check your blood sugars at home? ☐ Yes ☐ No Average reading: _____

Do you take any blood thinners (aspirin, Plavix, Coumadin, warfarin, Lovenox, etc)? ☐ Yes ☐ No

This Section Completed by Physician

I have reviewed this history form with the patient _____ _____

Courtney Amor, MD

Patient Medication List

Patient Name: _____

Today's Date: _____

Please list all medications you are taking, including vitamins and herbal supplements

Name of Medication	Strength/Dose	How many times per day?	Prescribing doctor