NEW CONDITION HISTORY

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NAME:	D.O.B.	DATE:
HEIGHT:	WEIGHT:	DOMINANT HAND: R / L
PHARMACY:	ADDRESS:	PHONE:
REASON FOR VISIT:		DATE OF INJURY/ONSET:
HOW DID THE INJURY OCCUR?		
HAVE YOU HAD PREVIOUS TREATMENT/TESTING FOR THIS INJURY (XRAY, MRI, MEDICATIONS, ETC?) IF YES, FROM WHERE?		
PAIN LEVEL 0 1 2 3 4 5 6 7 8 9 10		
PREVIOUS INJURIES TO THIS AREA IN THE PAST?		
ANY CHANGES TO YOUR HEALTH OR INSURANCE COVERAGE SINCE YOUR LAST VISIT? Y / N PLEASE UPDATE HEALTH INFORMATION BELOW AND INSURANCE WITH OFFICE STAFF		

MEDICAL HISTORY (DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING?)

❏ ANEMIA	❏ DIABETES	❏ HIV / AIDS
❏ ANXIETY	❏ EPILEPSY	❏ KIDNEY DISEASE
❏ ARTHRITIS	❏ GLAUCOMA	❏ PSYCHIATRIC HISTORY
❏ ASTHMA/PULMONARY DISEASE	❏ GOUT	❏ SLEEP APNEA
❏ BLOOD CLOT	❏ HEART DISEASE	❏ STROKE
❏ CANCER	❏ HEPATITIS	❏ THYROID DISEASE
❏ DEPRESSION	❏ HIGH BLOOD PRESSURE	❏ TUBERCULOSIS
	❏ HIGH CHOLESTEROL	❏ NONE

OTHER CONDITIONS:

PAST SURGICAL HISTORY:		
LIST ALL MEDICATIONS AND DOSAGE:		
ALLERGIES AND REACTIONS:		
HAVE YOU EVER SMOKED? Y / N	IF YES, HOW MUCH PER DAY?	QUIT DATE:
DO YOU DRINK ALCOHOL? Y / N	IF YES,HOW MANY DRINKS A WEEK?	
IF APPLICABLE, CARDIOLOGIST NAME:	CITY:	LAST VISIT:
HAVE YOU TESTED POSITIVE FOR COVID-19 IN THE LAST 3 MONTHS? Y / N		TEST DATE: