



Bart L. Eastwood, D.O.
New Patient Medical History

Name: _____ Today's Date: _____
Age: _____ Phone number: _____
Referred by: _____ Date of Injury/Onset of symptoms: _____

Reason for visit. Describe injury or onset in detail: LEFT RIGHT _____

Pain: Sharp Dull Stabbing Burning Other: _____
 Constant Intermittent **Intensity:** 0—1—2—3—4—5—6—7—8—9—10

Location (describe): _____

Does the pain go anywhere else (describe)? _____

What makes pain worse?: _____

What makes pain better? Rest Activity Modification Ice/Heat Meds

Other: _____

What other symptoms are present? _____

What treatments have you attempted and what effect? (PT, meds, injections) _____

Can you work or participate in sports with current symptom? NO YES

Do you have light duty available at work? NO YES

Past Medical and Family History (check all that apply **You** **Family History**)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> <input type="checkbox"/> COPD | <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Reflux | <input type="checkbox"/> <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> <input type="checkbox"/> Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Seizures |
| <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> <input type="checkbox"/> HIV | | |
- Other: _____

Past Surgical History (check all that apply)

- | | | | |
|---------------------------------------|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Hernia | <input type="checkbox"/> Breast |
| <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Heart Valve | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Spine/Neck |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Rotator Cuff | <input type="checkbox"/> Hysterectomy |
- Other: _____

Drug Allergies (list all known drug allergies)

Medications: (please list all prescription and over the counter medications and supplements)

Separate List Attached

Social History

Single Married Divorced Widowed Children? NO YES # _____

Do you smoke? NO YES _____ packs per day

Do you drink alcohol? NO YES Do you use drugs? NO YES (list) _____

What is your occupation? _____

Do you exercise regularly? NO Yes _____ days per week

Do you participate in sports? NO YES (list) _____

Review of Systems

Do you currently or frequently have: (check all that apply)

Constitutional

- Weight loss
- Weight gain
- Fever
- Chills

Eyes

- Blurred vision
- Double vision

Ears, Nose, Throat

- Hearing loss
- Ringing in ears
- Congestion
- Sore throat
- Respiratory**
- Shortness of breath
- Wheezing
- Cough
- Coughing blood

Cardiovascular

- Chest pain
- Palpitations

Genitourinary

- Painful urination
- Blood in urine
- Urgency/frequency
- Incontinence

Gastrointestinal

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Incontinence

Skin

- Rash
- Skin lesion

- Nail problems

Neurological

- Headaches
- Seizures
- Dizziness
- Balance problems
- Numbness/tingling
- Weakness

Endocrine

- Thirst
- Tired/sluggish
- Hot
- Cold

Hematologic

- Bleeding problems
- Bruising
- Limb swelling

Psychiatric

- Depression
- Anxiety
- Insomnia
- Addiction
- Drug use

Musculoskeletal (other than current complaint)

Joint pain (list) _____

- Back pain
- Neck pain
- Joint stiffness
- Joint swelling
- Gout

Other Medical

Concerns: (list)

Height: _____

Weight: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

