AIM

ATHLETIC INSTITUTE OF MEDICINE, LTD
Thomas J. Wall, M.D., PhD
PATIENT HISTORY
Please PRINT and fill our completely.

Today's Date: _____

Name: _____ Date of birth: _____ Age: _____

Occupation: _____ Hand Dominance: ☐ Right ☐ Left Height: _____ Weight: _____

Referring Doctor: _____ Family Doctor: _____

What body part is injured? _____ ☐ Right ☐ Left

Is this injury CHRONIC ☐ Yes ☐ No If YES, how long has it been going on for?
_____

Is this injury NEW as a result of a specific injury? ☐ Yes ☐ No If YES, date of injury/accident: ____ ____ ____

Describe in your own words how the initial injury occurred and how it limits your current level of activity:
_____

Did your problem begin following: ☐ Work Injury? ☐ Motor Vehicle Accident ☐ Sport Injury
Have you had any PRIOR accidents? ☐ Yes ☐ No If yes, please list:

Date:	Area Injured	Time off Work	Who treated you?
_____	_____	_____	_____

Do you currently have an attorney for this accident? ☐ Yes ☐ No

Please rate your pain on a scale of 1 to 10 (10 being the most painful):
Best: 0 1 2 3 4 5 6 7 8 9 10
Worst: 0 1 2 3 4 5 6 7 8 9 10

Is the pain: ☐ Worsening ☐ Improving ☐ No change ☐ Constant ☐ Comes & Goes
☐ Sharp ☐ Dull ☐ Aching ☐ Stabbing ☐ Throbbing ☐ Burning

What symptoms are you experiencing? ☐ Locking ☐ Catching ☐ Giving Way ☐ Popping ☐ Grinding
☐ Swelling ☐ Numbness ☐ Tingling ☐Weakness ☐ Other (describe)
_____

What, if anything, makes your symptoms better? ☐ Rest ☐ Activity ☐ Cold Therapy ☐ Heat Therapy
☐ Medication ☐ Physical therapy ☐ Other: _____

What, if anything, makes your symptoms worse? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐Twisting
☐ Bending ☐ Squatting ☐ Kneeling ☐Stairs☐ Sitting
☐ Overhead activities ☐ Taking off shirt ☐ Washing hair

Have you seen another physician for this injury? ☐ Yes ☐ No If yes, who?
_____

What treatments have you tried? ☐ Nothing ☐ Physical Therapy ☐ Exercise ☐ Acupuncture ☐Chiropractic
☐ Bracing ☐ Injections (ie: Synvisc, Supartz, Steroid) ☐ Ice
☐ Decreased Activity ☐ Medications _____

Have you had any of the following tests/studies? Please list the test done, the date (month/year) & what facility.

	TEST	DATE	Facility
☐ X-rays	_____	_____	_____
☐ MRI	_____	_____	_____
☐ CT scan	_____	_____	_____
☐ EMG/NCV	_____	_____	_____

Practitioner's Initials/Date_____

PAST MEDICAL HISTORY

Check if you currently suffer or have previously suffered from:

☐ High blood pressure
☐ Osteoporosis
☐ Deep vein thrombosis
☐ Kidney Disease/Problem
☐ Liver Disease or attack
☐ Seizure
☐ Heart Disease or attack
☐ Arthritis
☐ Stroke
☐ Thyroid ☐Hyper ☐Hypo
☐ Cancer (where?)
☐ Atrial Fib
☐ Tuberculosis
☐ Elevated cholesterol
☐ Ulcer Disease
☐ Pulmonary embolism
☐ Polio
☐ Gastritis
☐ Rheumatic Fever
☐ Reflux Disease (GERD)
☐ Gout
☐ Asthma
☐ Depression
☐ Diabetes

☐ Others, please list:

_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, when? _____

GASTROINTESTINAL HISTORY

Do you have a history of Peptic Ulcer Disease? ☐ Yes ☐ No If yes, When? _____
Do you have a history of GI, stomach bleed? ☐ Yes ☐ No If yes, When? _____
Do you take any medications for your stomach? (Please include over the counter medication, i.e. Pepcid, Tums, Zantac, Etc., dosage and frequency)

_____

PAST SURGICAL HISTORY

Please list all surgeries you have had in the past:

Type of surgery	Date	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had any problems with Anesthesia? ☐ YES ☐ NO Please explain if YES:

_____

_____

ALLERGIES

Are you allergic to any medication? ☐Yes ☐**No known drug allergies**
If **YES,** please list all medications that you are allergic to and the associated reaction (i.e.Penicillin (hives) etc.):

_____

Are you allergic to: Sulfa? ☐ Yes ☐ No **Latex?** ☐ Yes ☐ No

MEDICATIONS

Please list all medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin, and any over the counter medications. Include Vitamin, Mineral and Herb supplements.

Medication	**Dosage**	**Frequency**
_____	_____	_____
_____	_____	_____

Practitioner's Initials/Date _____

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Living with other ☐ Living alone

Recreational Activities: _____

Tobacco Use: ☐ Yes ☐ No Type: _____ Duration: _____ Quit Date: _____

Alcohol Use: ☐ Yes ☐ No Frequency: _____

FAMILY HISTORY

Please check family history conditions:

☐ Blood Clots ☐ Diabetes ☐ Hypertension ☐ Rheumatoid Arthritis ☐ Anesthesia problems

☐ Cancer ☐ Heart Disease ☐ Osteoporosis ☐ Stroke ☐ Seizures ☐ Bleeding Disorders

☐ Deep venous thrombosis ☐ Pulmonary Embolism

Please describe any immediate family history medical problems: _____

_____

Current Work Status

☐ Regular ☐ Light duty- (how long? _____) ☐ Not working due to this problem
☐ Disabled ☐ Retired ☐ Student

When is the last date you worked your regular job? _____

Are you currently receiving or plan to apply for: Disability: ☐ Yes ☐ No
Worker's Comp: ☐ Yes ☐ No
Unemployment: ☐Yes ☐ No

PLEASE SIGN: The information on these forms is accurate to the best of my knowledge.

_____

Patient Signature or Legal Guardian **Date**

Reviewed by: Thomas J. Wall, M.D. _____ **Date:** _____

REVIEW OF SYSTEMS:

Please circle any symptoms you may have, and describe:

1. **CONSTITUTIONAL**
   - A. Recent weight change?
   - B. Change or loss of appetite?
   - C. Fevers?
   - D. Chills?
   - E. Night sweats?
   - F. Weakness fatigue?

2. **EYES**
   - A. Vision changes?
   - B. Glasses/contacts?
   - C. Glaucoma?
   - D. Eye infections (iritis)?
   - E. Loss of vision?

3. **EARS, NOSE AND THROAT**
   - A. Decreased or loss of hearing?
   - B. Ear ache or infection?
   - C. Tinnitus (ringing in ear)?
   - D. Nasal stuffiness/discharge?
   - E. Nose bleeds?
   - F. Sore throat?
   - G. Dental problems?
   - H. Dentures?
   - I. Difficult swallowing?

4. **CARDIOVASCULAR**
   - A. Chest pain?
   - B. Shortness of breath?
   - C. Palpitations?
   - D. Swelling in legs?
   - E. Please list most recent heart tests w/ name of facility, date and contact number.

     _____

5. **RESPIRATORY**
   - A. Cough?
   - B. Wheezing/asthma?
   - C. Pneumonia or bronchitis?
   - D. Shortness of breath?

6. **GASTROINTESTINAL**
   - A. Abdominal pain?
   - B. Nausea or vomiting?
   - C. Constipation?
   - D. Diarrhea
   - E. Heart burn/Acid reflux?

7. **GENITOURINARY?**
   - A. Increase frequency of urination?
   - B. Pain/burning when you urinate?
   - C. Frequent infection of urine?
   - D. Incontinence (loss of control)?
   - E. Reduced force of urination?

8. **MUSCULOSKELETAL**
   - A. Muscle aches?
   - B. Joint pains/stiffness (arthritis)?
   - C. Swelling of joints?

9. **SKIN**
   - A. Rash?
   - B. Lumps or sores?
   - C. Changes in hair or nails?
   - D. Dryness?
   - E. Ulcers?
   - F. Abdominal scars?

10. **PSYCHIATRIC**
    - A. Depression?
    - B. Mood swings?
    - C. Anger?
    - D. Nervous/anxiety?

11. **NEUROLOGICAL**
    - A. Headaches?
    - B. Fainting/blackouts?
    - C. Tremors/involuntary movements?
    - D. Numbness, tingling?
    - E. Dizziness?
    - F. Muscle weakness?

12. **ENDOCRINE**
    - A. Excessive thirst or hunger?
    - B. Hot/cold intolerance?
    - C. Hot flashes?

13. **HEMATOLOGICAL**
    - A. Easy bruising or bleeding?
    - B. Past blood transfusions?

Practitioner's Initials/Date _____