Steven B. Haas, MD

Patient History & Physical Form

Please complete this history form and return it to the nurse when you are put in an examination room. Do not leave any questions blank, as your answers are needed in order to evaluate and treat you. If you have any questions, please do not hesitate to ask.

Complaint: ____________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Is this a work related or auto injury (check one)  ☐ Yes  ☐ No
If yes, date of accident __________________

MEDICAL HISTORY:

Name of primary medical doctor: ________________________
Telephone# of primary medical doctor: ____________________
Your height_____________ Your weight__________________

Have you ever had any of the following medical conditions? Please answer yes or no and do not leave any lines blank.

☐ Yes  ☐ No  Chest Pain
☐ Yes  ☐ No  Shortness of Breath
☐ Yes  ☐ No  Heart Attack
☐ Yes  ☐ No  High Cholesterol
☐ Yes  ☐ No  High Blood Pressure
☐ Yes  ☐ No  Diabetes
☐ Yes  ☐ No  Peripheral Vascular Disease
☐ Yes  ☐ No  Stomach Ulcer
☐ Yes  ☐ No  Blood Clots  If yes, Treated With Blood Thinner  ☐ Yes  ☐ No
☐ Yes  ☐ No  Asthma
☐ Yes  ☐ No  Cancer
☐ Yes  ☐ No  Frequent Urinary Tract, Kidney or Bladder Infections
☐ Yes  ☐ No  Frequent or Painful Urination
☐ Yes  ☐ No  Depression
☐ Yes  ☐ No  Rheumatoid/Systemic Inflammatory Disease

List any other medical conditions:
Do you have a family history of heart disease, if yes please explain?

Do you have a family history of orthopedic or arthritic conditions?
Please list all surgeries you have had. Make sure to include dates whenever possible:

Do you have any allergies to medications? If so, please list the names of the medications.

Please list all medications you take on a regular basis. Make sure to include dosages whenever possible.

Do you smoke? If so, please state how much.

Do you drink alcohol? How often and how much?

Do you require any dental work? If so, please explain:

What current leisure activities do you participate in? Please check all that apply.

- Golf
- Tennis
- Swimming
- Biking
- Hiking
- Exercise Walking
- Boating
- Snow Skiing
- Gardening
- Bowling
- Other ______________________

What leisure activities are you expecting to return to? Please check all that apply.

- Golf
- Tennis
- Swimming
- Biking
- Hiking
- Exercise Walking
- Boating
- Snow Skiing
- Gardening
- Bowling
- Other ______________________