Kenton H. Fibel, MD.

Confidential Medical History

Today's Date________

Name: ________________________________ Age: ________ DOB: ______________________

○ Right Handed ○ Left Handed Sex: ○ Male ○ Female

Home # ______________________________ Work # ____________________________________

Occupation: ___________________________ Referring Doctor: ____________________________

Chief Complaint: ____

Date of injury or onset of symptoms: ____

Describe the location of your pain: ____

Describe the injury or problem: ____

____

____

Rate Your Pain on a Scale of 0-10 *(0 = No Pain 10 = Extreme Pain):*

Right now: __________ At best: __________ At worst: __________

Quality of Pain (sharp, dull, burning, etc): ____

Is the pain constant or intermittent? ____

What makes it better? ____

What makes it worse? ____

Have you had any of the following tests or treatments for this problem? (please check)

Tests	*Date(s) of your tests*	*Treatments* (Please name & describe if they helped)	
☐ X-RAY	_______________________	☐ MEDICATIONS	_______________________
☐ MRI	_______________________	☐ INJECTIONS	_______________________
☐ CT SCAN	_______________________	☐ SURGERY	_______________________
☐ BONE SCAN	_______________________	☐ PHYSICAL THERAPY	_______________________
☐ OTHER TESTS	_______________________	☐ OTHER TREATMENTS	_______________________

Prior to having your above complaint, please describe your typical physical activities and hours/mileage for each per week (sports, training, cardio, weights, yoga, work commute, etc):

1. ____
2. ____
3. ____

Have you ever had this injury/problem before (if yes, please describe)? ○ Yes ○ No

____

Would you like us to send copies of your notes to your primary care physician? ○ Yes ○ No

Primary Care Physician ______________________________

Mailing Address ______________________________

Phone # ______________ Fax # ______________

Your Medical History

Do you have any medical problems? (Diabetes, high blood pressure, etc) ______________

Have you ever been hospitalized? ○ Y ○ N If yes, why? ______________

Have you ever had surgery? ○ Y ○ N If yes, why and when? ______________

List of medications ______________

Are you allergic to any medication? ○ Y ○ N If yes, list. ______________

Are you allergic to any contrast dyes? ○ Y ○ N

Are you allergic or sensitive to latex? ○ Y ○ N

Family History

Does anyone in your family have any of the following problems? (please check)

☐ Heart disease ☐ High blood pressure ☐ Anesthesia complications ☐ Osteoporosis

☐ Cancer ☐ Nerve problems ☐ Blood problems (anemia, abnormal bleeding) ☐ Hip fracture

☐ Stroke ☐ Diabetes ☐ Osteoarthritis ☐ Other: ______________

Current Symptoms or Problems

Please check Yes or No for any of the following that apply to you:

Yes	No	
☐	☐	Recent weight change
☐	☐	Change in bowel habits (also blood in stools)
☐	☐	Fatigue/weakness
☐	☐	Blood disorder or blood transfusion
☐	☐	Fever, chills
☐	☐	Easy bleeding
☐	☐	Easy bruising
☐	☐	Skin rash/disease
☐	☐	Change in urinary habits (including pain, blood in urine, trouble stopping/starting your urine)
☐	☐	Kidney disease or kidney stones
☐	☐	Vision problems/eye disease
☐	☐	Eating disorder
☐	☐	Nose/throat problem
☐	☐	Hearing problems/ear disease
☐	☐	Stomach pain or heartburn

Yes	No	
☐	☐	Ulcers
☐	☐	Hepatitis or gallbladder disease
☐	☐	Frequent headaches
☐	☐	Fainting spells
☐	☐	Seizures
☐	☐	Problems with coordination
☐	☐	Depression
☐	☐	Thyroid problems
☐	☐	Change in appetite or thirst
☐	☐	Shortness of breath or wheezing
☐	☐	Frequent cough
☐	☐	Chest pain
☐	☐	Heart murmur
☐	☐	Irregular heart beat
☐	☐	Heart disease
☐	☐	Swollen legs or feet

Social History and Health Habits

Do you smoke cigarettes? ○ Y ○ N ______ packs/day For how long?______yrs

Have you smoked in the past? ○ Y ○ N ______ packs/day For how long?______yrs Quit date __________

Do you drink alcohol? ○ Y ○ N ______ drinks/wk

Have you fallen at least twice in the past 12 months? ○ Y ○ N

Have you fallen and sustained an injury in the past 12 months? ○ Y ○ N

Number of Children: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 or more

Marital Status: ○ Married ○ Single ○ Widowed ○ Divorced

How would you describe your level of physical activity over the past six months?

☐ Inactive - just daily activity
☐ Light - some walking, gardening, occasional weekend recreational activity
☐ Moderate - regular (3x per week) moderate exercise and occasional weekend sports
☐ Vigorous - regular (3-5x per week) vigorous exercise and/or sports activity
☐ Intense - competitive vigorous sports training

Height__________feet/inches Weight___________lb

Do you consider your current weight ideal? ○ Y ○ N If no, list your ideal weight ____________

Do you have questions about healthy ways to control your weight? ○ Y ○ N

Are there any specific questions that you would like to discuss today?

1. ____
2. ____
3. ____

Signed by Patient: ______________________________ ***Date:*** ________________

Office only: *Reviewed by:* ______________________________ *Date:* ________________