PATIENT HISTORY
FOR MATTHEW D. COLLARD, D.O.

(TO BE UPDATED ANNUALLY)

(PLEASE PRINT)

Name _____ **Date or Birth** __/__/__ **Age**_____ **Date** _____

1) **Who referred you to this office?** _____
2) **Who is your current primary care physician?** _____
3) **Who is your cardiologist?** _____

4) **What is your chief problem area at this time? Right/Left** _____
5) **When does the problem occur? (Night, day, what activity or at rest)** _____
6) **How long has the problem been present?** _____
7) **What are your current symptoms?** _____
8) **What is your pain level on a scale from 0 to 10?** 0 is no pain and 10 is the most severe pain
   Current pain level _____ **Pain level at the time of injury** _____
   Your pain level at its worst_____ **Your pain at its best** _____ please use the scale for each
9) **Did you have an injury? Yes or No** please circle one **(if no, please go to question 10)**
   Date of injury: ___/__/___ **Where did the injury occur ?** _____
   How did the injury occur? _____
   _____
   How was the injury treated? _____
   Results of treatment: _____
10) **Have you had a previous injury or work related injury to this same area? Yes or No**
   -Have you had previous surgery on the same area? Yes or No _____
   -Date of previous injury: ___/___/___ **-How did it occur?** _____
11) **Occupation:** _____
   Employer: _____ **How long have you been at this job?** _____
12) **Have you missed from work?**_____ **How much?**_____ **Are you on light duty? Yes or No**
13) **Is this a work-related injury? Yes or No Is an Attorney working on your problem? Yes or No**
14) **For this problem have you had any of the following tests?**
   ☐ **X-rays** ☐ **MRI** ☐ **Nerve Studies** ☐ **CT Scan** ☐ **Bone Scan** (check all that apply)
   When?_____ **Facility Name & Location?**_____
15) **Height** _____ **Weight** _____ **Right or Left handed (circle one)**
16) **Have you ever had MRSA (methicillin-resistant staphylococcus aureus) Yes or No**
17) **Do you have any allergies to metals or jewelry? Yes or No**
18) **Do you have any allergies to latex? Yes or No**
19) **Do you take blood thinners of any kind? Yes or No please list**_____
20) **Have you ever had a blood clot, deep vein thrombosis (DVT), or pulmonary embolism (PE)?**
   Yes or No if yes which? _____
21) **Are you currently pregnant? Yes or No** for x-ray and medication purposes

ALLERGIES (List all medication allergies)

Medications (List all)	

HOSPITALIZATIONS and SURGERIES	**List all surgeries**
Surgery	**Date**

Any Problems with Anesthesia? Yes or No

Social History:

Are you married Yes / No Years _____

Do you have children Yes / No Number ___
Do you use a walker or cane?
Do you smoke? Yes/No Packs per day? ____
Do you drink alcohol? Yes / No
Drinks per week? _____
Any history of drug or alcohol abuse? Yes/No

Family History *(Check those that apply)*

	Self	Mom	Dad	Sibling
Heart Disease/ MI	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer type _____	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Acid Reflux/Ulcer	☐	☐	☐	☐

Your Health History

(PLEASE CIRCLE all that apply)

CONSTITUTIONAL - **NONE**
Fever Chills Weight Loss

EAR, NOSE, THROAT - **NONE**
Dizziness Ear Problems Sinus Problems
Cold Sore Deafness Motion Sickness

CARDIOVASCULAR - **NONE**
Palpitations Heart Murmur Chest Pains
High Blood Pressure High Cholesterol MI
Vascular Disease Pacemaker

RESPIRATORY - **NONE**
Asthma Bronchitis Emphysema
Pneumonia Shortness of Breath Tuberculosis

GASTROINTESTINAL - **NONE**
Ulcer Gall Bladder Problems
Diarrhea Black Stool Blood in Stool

GENITOURINARY - **NONE**
Prostate Disease Frequent Urination
Pain Urination Blood in Urine

MUSCULOSKELETAL - **NONE**
Arthritis Joint Pains
Rheumatoid Arthritis Gout

ENDOCRINE - **NONE**
Diabetes Thyroid Disease

NEUROLOGIC - **NONE**
Headaches Migraines
Strokes Seizures

PSYCHIATRIC - **NONE**
Depression Nervousness Anxiety

HEMATOLOGIC/LYMPHATIC - **NONE**
Bleeding Problems Anemia Easy bruising
DVT PE Blood Clot

SKIN - **NONE**
Rashes Itching

INFECTIOUS DISEASE Hepatitis HIV

Pain Level Today

* Circle the number on the line below that represents your pain at its least.

* Circle the number on the line below that represents your pain at its worst.

* Place an "X" on the line below that represents your pain **right now**.

0	1	2	3	4	5	6	7	8	9	10
No Pain			**Moderate**			**Severe**				**Excruciating**

Indicate on the diagram below where your pain is located and what type of pain you feel **at the present time**. Use the symbols to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

>>> Sharp
/// Stabbing
XXX Burning
OOO Pins & Needles
==== Numbness or Tingling
+++ Aching