

PATIENT HISTORY
FOR MATTHEW D. COLLARD, D.O.
 (TO BE UPDATED ANNUALLY)

(PLEASE PRINT)

Name _____ Date _____

Social Security Number	Date of Birth	Age

1) Who referred you to this office? _____
 Address _____

2) What is your chief problem at this time? _____

3) When does the problem occur? (Night, day, with activity or at rest) _____

4) How long has the problem been present? _____

5) Did you have an injury? Yes _____ No _____ (if no, please go to question 7)
 Date of injury: ___/___/___ Where did the injury occur? ___at work ___sport ___other
 How did the injury occur? _____

 How was the injury treated? _____
 Were you treated by an ER or physician? _____
 Results of treatment: _____

6) Have you had a previous injury or work related injury to this same area? Yes_____ No_____
 -Date of previous injury: ___/___/___ -How did it occur? _____
 -Residual symptoms: _____

7) Occupation: _____
 Employer: _____ How long have you been at this job? _____

8) How much time have you missed from work? _____

9) Is this a work-related injury? Yes_____ No_____

10) Is an Attorney working on your problem? Yes_____ No_____

11) For the problem you are to be evaluated for, have you had any of the following tests?

	When?	Facility Name & Location?
<input type="checkbox"/> X-rays _____		
<input type="checkbox"/> MRI _____		
<input type="checkbox"/> Nerve Studies _____		
<input type="checkbox"/> CT Scan _____		
<input type="checkbox"/> Bone Scan _____		

12) Height _____ Weight _____ Right or Left handed (circle one)

13) Are you currently pregnant? Yes _____ No _____

ALLERGIES

Medications	Dose

HOSPITALIZATIONS and SURGERIES	
Surgery	Date

Social History:

Are you married Yes / No
 Number of years _____
 Do you have children Yes / No
 Number _____
 Do you live with someone who can help you?
 Yes / No
 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your Health History

(PLEASE CIRCLE all that apply)

CHILDHOOD HISTORY - NONE

Scarlet Fever	Rubella	Rheumatic Fever
Polio	Mumps	Diphtheria
Measles	Tetanus	

CONSTITUTIONAL - NONE

Fever	Chills	Weight Loss
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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	
Vascular Disease	Pacemaker	

RESPIRATORY - NONE

Asthma	Bronchitis	Emphysema
Pneumonia	Shortness of Breath	

GASTROINTESTINAL - NONE

Ulcer	Gall Bladder Problems
Hepatitis	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
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NEUROLOGIC - NONE

Headaches	Migraines
Strokes	Seizures

PSYCHIATRIC - NONE

Depression	Nervousness	Anxiety
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HEMATOLOGIC/LYMPHATIC - NONE

Bleeding Problems	Anemia	Easy bruising
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SKIN - NONE

Rashes	Itching
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INFECTIOUS DISEASE Hepatitis HIV

