BETH A. PURDY, MD, PLC **NEW PATIENT HISTORY/UPDATED HISTORY**

Patient Name: _____ PIN [office use only] _____
Date: _____
Primary Care Physician: _____
Age: _____ ☐Right handed ☐Left handed ☐Male ☐Female
What are you being seen for today? _____
Date of onset/injury: _____ Pain level 0-10 (10 worst) _____/10
Was this a result of an accident: ☐No ☐Yes→☐Auto ☐Home ☐Work ☐Other _____
Other Physicians/providers seen for this problem: _____
Treatments to date: _____
Testing already performed: _____

CURRENT REVIEW OF SYSTEMS: **please check any symptoms you currently have:**

☐ Chills	☐ Shortness of breath	☐ Urinary incontinence
☐ Fever	☐ Productive cough	☐ Generalized joint pain
☐ Weight loss	☐ Wheezing	☐ Generalized muscle pain
☐ Weight gain	☐ Coughing blood	☐ Rash
☐ Night sweats	☐ Difficulty swallowing	☐ Hives
☐ Sinus pain/pressure	☐ Stomach/abdominal pain	☐ Headache
☐ Recent vision changes	☐ Recent change in bowel habits	☐ Passing out
☐ Dry eyes	☐ Heartburn/indigestion	☐ Dizziness
☐ Hearing loss	☐ Nausea/vomiting	☐ Numbness, tingling _____
☐ Snoring	☐ Blood in stool	☐ Depression
☐ Chest pain	☐ Frequent urination	☐ Claustrophobia
☐ Ankle swelling (not injured)	☐ Blood in urine	☐ Bleeding problems
☐ Palpitations	☐ Painful urination	☐ Seasonal allergies

PAST MEDICAL HISTORY: **indicate any illnesses you have had:**

Previous upper extremity injuries: _____

☐ Abnormal Heart Beat	☐ Thyroid disease _____	☐ Depression
☐ Pacemaker	☐ Osteoporosis	☐ Osteoarthritis
☐ Heart Disease _____	☐ Anemia	☐ Rheumatoid arthritis
☐ Coronary Artery Disease or MI	☐ Pregnant now	☐ Lupus
☐ Cardiac Stent	☐ Migraines	☐ Gout
☐ Hypertension	☐ Seizures	☐ Psoriasis
☐ Blood Clot/DVT	☐ Hepatitis, type _____	☐ Fibromyalgia
☐ Pulmonary Embolus	☐ HIV/AIDS	☐ Dupuytren's contracture
☐ Peripheral Vascular Disease	☐ Tuberculosis	☐ Kidney disease _____
☐ Stroke	☐ Valley Fever	☐ Bleeding Disorder _____
☐ Sleep Apnea	☐ GERD/Reflux	☐ Other Medical Problems
☐ Use CPAP	☐ Peptic Ulcers	_____
☐ Asthma	☐ Cancer _____	_____
☐ Lung Disease _____	☐ Liver Disease _____	_____
☐ Diabetes, taking pills	☐ Glaucoma	_____
☐ Diabetes, requiring insulin	☐ Anxiety Disorder	_____

ALLERGIES: List allergy and **REACTION**, or ☐ NO KNOWN MEDICAL ALLERGIES

- Allergy: _____
  Reaction: _____
- Allergy: _____
  Reaction: _____
- Allergy: _____
  Reaction: _____
- Allergy: _____
  Reaction: _____

MEDICATION DOSAGES, including over the counter and supplements:

1 _____	5 _____	9 _____
2 _____	6 _____	10 _____
3 _____	7 _____	11 _____
4 _____	8 _____	12 _____

PAST SURGICAL HISTORY: **List ALL previous surgeries and dates:**

1 _____	5 _____	9 _____
2 _____	6 _____	10 _____
3 _____	7 _____	11 _____
4 _____	8 _____	12 _____

FAMILY HISTORY: **indicate which relative(s) have the problem:**

☐ Hypertension _____	☐ Stroke _____	☐ Bleeding disorder _____
☐ Heart disease _____	☐ Diabetes _____	☐ Anesthesia problem _____
☐ Asthma _____	☐ Cancer _____	☐ Other _____

SOCIAL HISTORY:

Do you smoke: ☐No ☐Yes→how much? _____ how many years? _____
Did you previously smoke: ☐No ☐Yes→how much? _____ how long? _____ Quit: _____
Do you use chewing tobacco: ☐No ☐Yes→how much? _____
Do you drink alcohol: ☐No ☐Yes→#drinks_____/☐day ☐week ☐month ☐year
Have you used drugs: ☐No ☐Yes→☐marijuana ☐methamphetamine ☐cocaine ☐Other _____
Do you still use drugs: ☐No ☐Yes ☐Quit (when): _____
Current work status: ☐Full Duty ☐Light Duty ☐Off Work ☐Retired
Occupation/Job Title: _____
Employer: _____
Students Only: Year in School _____ School attending: _____
Sports you play: _____
Hobbies/Avocations: _____
Do you live ☐alone, or ☐with others?

Last Tetanus Shot: _____
Last Pneumonia Vaccination: _____
Other Recent Vaccinations (Shingles, Influenza, etc.): _____

Current Height: _____ Current Weight: _____

Patient Signature (Legal Guardian ☐) _____

Date of Signature: _____