

**COSM PATIENT MEDICAL HISTORY** Today's Date \_\_\_\_\_ Birth date \_\_\_\_\_

Name \_\_\_\_\_ Reason for visit: \_\_\_\_\_

**Medication Allergies**  Yes  No (Please list all of your medications and allergies on the Medication Summary)

**Other Allergies: Seasonal**  Yes  No **Metals**  Yes  No **Latex**  Yes  No **Anesthetics**  Yes  No **Eggs/Poultry**  Yes  No

**SURGICAL HISTORY**

Previous Surgery / Date	Surgeon (if known)	Previous Surgery / Date	Surgeon (if known)

**Problems with Anesthesia:**  Yes; Explain: \_\_\_\_\_  No **History of Malignant Hyperthermia:**  Yes  No

**MEDICAL HISTORY:** (Circle all that apply and / or list)

Alzheimer's Anemia Anxiety Asthma Blind Blood Clots Cancer Congestive Heart Failure COPD Deaf Dementia  
Depression Diabetes Emphysema Epilepsy Fibromyalgia Fractures Gout Heart Attack Heart Disease  
High Cholesterol Hypertension Irritable Bowel Kidney Disease Liver Disease Mental Disease Osteoporosis Osteoarthritis  
Pneumonia Rheumatoid Arthritis Seizures Sleep Apnea Stroke Tuberculosis Thyroid Disease Ulcers

**REVIEW OF SYSTEMS** (Circle all that apply)

**General** recent weight change fatigue fever chills night sweats risk factors for HIV/AIDS  
**Skin / Breasts** itching rash sores lumps painful skin moles excessive bleeding nipple discharge  
**Eye/Ear/Nose/Throat** blurred or double vision blind spots hearing problems sinus problems hoarseness gum/tooth problems  
difficulty swallowing  
**Lungs** chronic cough shortness of breath oxygen use snoring CPAP wheezing infections coughing blood  
**Heart** chest pain high blood pressure leg swelling fainting blood clots low blood count  
**Gastrointestinal** nausea vomiting heartburn abdominal pain constipation bloody stools diarrhea  
**Genitourinary (female)** menopause possibility of pregnancy incontinence painful urination blood in urine abnormal vaginal  
bleeding vaginal or pelvic infections  
**Genitourinary (male)** incontinence painful urination blood in urine trouble starting stream impotence prostate problems  
**Musculoskeletal** fracture muscle or tendon injuries joint swelling or pain previous infections childhood deformity or braces  
**Neurologic** dizziness headache slurred speech seizures numbness or tingling weakness head injury  
**Endocrine** diabetes thyroid trouble excessive thirst uncomfortably hot or cold fatigue  
**Psychiatric** feelings of excessive sadness or stress anxiety suicidal thoughts chemical dependency

**FAMILY HISTORY**

Do you have a family history of:  arthritis  diseases of the muscles, bones or nervous system  bleeding tendencies

**SOCIAL HISTORY**

Marital status: S M W D Who lives at home with you? \_\_\_\_\_

**Tobacco**  Yes; how much? \_\_\_\_\_  No **Alcohol**  Yes; how much? \_\_\_\_\_  No **Recreational drugs**  Yes  No

Hobbies: \_\_\_\_\_ Exercise:  Regular  Occasional  Rare  Never Explain: \_\_\_\_\_

Normal form of ambulation:  independent  walker  cane  non-ambulatory

**Patient or Guardian's Signature**

**Date**

**This page to be completed by COSM Staff during your visit.**

Name \_\_\_\_\_ MR \_\_\_\_\_ Date \_\_\_\_\_

Family Dr. \_\_\_\_\_ Referring Dr. \_\_\_\_\_

Age \_\_\_\_\_ Temperature \_\_\_\_\_ Pulse \_\_\_\_\_ Bp \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_ Dominant Hand  Rt  Lt

Diabetic  Yes  No  Diet Controlled  Oral Hypoglycemic  Insulin Dependent Shoe Size (if applicable) \_\_\_\_\_

**CHIEF COMPLAINT:** \_\_\_\_\_  No known injury Date of Injury \_\_\_\_\_

MVA  Yes  No Job related  Yes  No Claim filed  Yes  No Attorney Involvement  Yes  No

**ONSET:** Suddenly on \_\_\_\_\_ Gradually since \_\_\_\_\_  Chronic  No previous history  Similar symptoms \_\_\_\_\_

**HX OF PRESENT ILLNESS:** \_\_\_\_\_

<u><b>Pain Location:</b></u>		<u><b>Radiation To:</b></u>	<u><b>Previous Testing</b></u>
Neck	Groin	Neck	X-ray _____ <input type="checkbox"/> CD/Films here <input type="checkbox"/> Online
Shoulder	Knee	Upper Arm	MRI _____ <input type="checkbox"/> CD/Films here <input type="checkbox"/> Online
Elbow	Ankle	Forearm	CT _____
Wrist	Foot	Hand	EMG _____
Hand	Heel	Finger	Other _____
Finger	Toe	Buttock	<u><b>Previous Treatments</b></u>
Low Back Pain		Thigh	<input type="checkbox"/> Chiropractic
Buttock		Calf	<input type="checkbox"/> Rehab _____
		Foot	<input type="checkbox"/> German Stabilization
<u><b>Associated Symptoms:</b></u>	<u><b>Aggravating Factors:</b></u>	<u><b>Ameliorating Factors:</b></u>	<input type="checkbox"/> Injections <input type="checkbox"/> Cortisone
			<input type="checkbox"/> Viscosupplementaion
Loss of motion	Prolonged sitting	Changing positions	<input type="checkbox"/> Epidural <input type="checkbox"/> Other
Loss of strength	Prolonged standing	Ice _____ Heat	<input type="checkbox"/> Splint <input type="checkbox"/> Brace
Edema	Prolonged walking	Standing	<input type="checkbox"/> Shoe inserts
Popping	Aggressive activity	Sitting	<input type="checkbox"/> Other _____
Buckling	Bending / Twisting	Walking	<u><b>Previous Medications</b></u>
Catching / Locking	Lifting	Progression of day	OTC _____
Numbness / Tingling	Kneeling /Squatting	Lying on side	
Bowel changes	Cutting / Pivoting	Lying w/knees up	
Bladder changes	Up stairs down	Lying flat on back	RX _____
Pain w/coughing	Upon rising in am	Supportive shoes	
Pain w/sneezing	Bare feet		
Pain at night			<u><b>NSAID Contraindication</b></u>
			<input type="checkbox"/> GI upset <input type="checkbox"/> GI bleeding/ulcer
			<input type="checkbox"/> Anticoagulants

Currently working?  Yes  No; last day worked: \_\_\_\_\_  Disabled: (reason) \_\_\_\_\_  Unemployed

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Length of Employment \_\_\_\_\_

Regular work:  Sedentary  Light  Medium  Heavy Job duties: \_\_\_\_\_ Currently on work restrictions?  Yes  No

PHYSICIAN SIGNATURE \_\_\_\_\_

Date \_\_\_\_\_

Assessment obtained by: \_\_\_\_\_