

COSM PATIENT HISTORY

Name: _____ Date: _____ Date of Birth: _____
Age: _____ Have you been seen by our physicians in the past? Yes / No
Referring physician: _____ Would you like information sent to them? Yes / No
Primary physician: _____ Would you like information sent to them? Yes / No
Hospital preference: _____
What problem are you here for? _____
How and when did it start? _____
Where did it happen? _____
Type of injury? Auto accident _____ Work injury _____ Accident _____ Other _____
Date this started? _____ Other treating physicians _____
Have you had prior treatment for this? _____
Medications (Name and Dose) _____

_____	Physical Therapy	Where _____	When _____
_____	Plain X-rays	Where _____	When _____
_____	MRI Scans	Where _____	When _____
_____	CAT Scans	Where _____	When _____
_____	Injection Therapy	Where _____	When _____
_____	Nerve Tests	Where _____	When _____
_____	Other Testing	Where _____	When _____

Prior surgery for this problem? (Surgeon/Date/Procedure) _____
What makes it better? _____
What makes it worse? _____
Similar problems in the past? _____
Prior injury to this area? _____
Other pertinent details? _____

Signature Date (Please see other side.....)

REVIEW OF SYSTEMS

Are you currently having or have you had problems with your:

	CIRCLE	Describe all yes responses		CIRCLE	Describe all yes responses
Eyes	No	Yes	_____	Balance Problems	No Yes _____
Ears, Nose, Throat	No	Yes	_____	Numbness/Tingling	No Yes _____
Lungs, Breathing	No	Yes	_____	Blackout/Fainting	No Yes _____
Digestion	No	Yes	_____	Mood/Sleep Problems	No Yes _____
Bowel Movement	No	Yes	_____	Auto Immune Disease	No Yes _____
Bladder Problems	No	Yes	_____	Cancer	No Yes _____
Diabetes	No	Yes	_____	Polio	No Yes _____
High Blood Pressure	No	Yes	_____	TB	No Yes _____
Bleeding Problems	No	Yes	_____	Epilepsy	No Yes _____

List all current medications and dosages: _____

Do you have any ALLERGIES to medicine? No Yes List: _____

Are you allergic to latex? No Yes

PAST MEDICAL HISTORY

Surgeries / Hospitalizations / Medical Problems	Year	Complications	Doctor
---	------	---------------	--------

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had general anesthesia? No Yes Have any problems with anesthesia? No Yes

SOCIAL HISTORY

Work in the home Employed (occupation/employer _____)

Student Daycare Retired Single Married Divorced Separated Widowed

Children? No Yes # _____ Do you live alone? No Yes

Exercise? Daily Weekly Monthly Rarely Never

What type of exercise? _____

History of substance abuse? No Yes What? _____

Smoke currently? No Yes _____ packs/day for _____ yrs. Previously smoked _____ packs/day for _____ yrs.

Quit smoking? This year less than a year ago less than 5 years ago less than 10 years ago

Drink alcohol? Daily 1-2 times per week 1-2 times per month 1-2 times per year

FAMILY HISTORY

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D	_____	_____
Grandmother (dad's)	A	D	_____	_____
Grandfather (mom's)	A	D	_____	_____
Grandfather (dad's)	A	D	_____	_____
Father	A	D	_____	_____
Mother	A	D	_____	_____
Sister / Brother	A	D	_____	_____
Sister / Brother	A	D	_____	_____
Sister / Brother	A	D	_____	_____