Today's Date: _____ PATIENT HISTORY FORM

This is a confidential record and will be kept in your doctor's office . Information contained here will not be released to anyone without your authorization to do so.

Please PRINT clearly **Please PRINT clearly**

Last Name

First Name

Date of Birth (month/ day/ year) ___/___/___

SSN# ___-___-____

Home Phone# (___) _____ **Cell Phone#** (___) _____

Male / Female **Age**: _____

Marital Status: M S D W

Text: Yes or No, please circle one

Street Address _____ Apt_____

City_____ State _____Zip _____

Email: _____ Primary Language: _____

Occupation at the time of accident
Driver, Construction, Sales, Student etc.

REFERRING DOCTOR:_____ Phone#_____

Address: _____ Fax#_____

TYPE OF ACCIDENT: Work Injury Car Accident Personal Injury Unknown

DETAILED DESCRIPTION OF EXACTLY WHAT HAPPENED, HOW YOU WERE INJURED:

_____

_____

_____

Date of Accident: ___/___/_____ Primary Language: _____

Are you working? Circle One Yes or No,

What was the date you stopped working ? _____,

if this is a Work related injury, what was your Job Title when you were injured? _____

Attorney: _____

Phone# _____

3rd Party Attorney: _____

Phone# _____

CHIEF COMPLAINT (briefly describe reason for visit): _____

_____

LOCATION OF THE PROBLEM

Low back Leg Neck Arm Other:_____

On a scale from 1 to 10, 10 being the worst pain, please circle the number that best describes your pain: 1 2 3 4 5 6 7 8 9 10

The pain is: Constant On-Off Dull then sharp Sharp shooting

When did you FIRST notice the problem?

Since accident 2 days ago 2 weeks ago 2 months ago Years

Does anything make the problem worse?

Moving around Standing Up Lying on the side Walking Sleeping

CIRCLE ALL PREVIOUS TREATMENTS

warm pack	ice pack	nerve block
exercise	massage	chiropractor
acupuncture	brace	physical therapy
TENS unit	traction	biofeedback
psychologist	epidurals	surgery

Is anything else occurring at the same time?

Nausea Headaches Rash

Does the problem interfere with your normal daily function? NO/ Yes, with:_____

_____

PAST MEDICAL, FAMILY & SOCIAL HISTORY

List any personal past illnesses and/or surgeries and when they occurred:

_____ _____

_____ _____

Allergies to medication: _____ Other Allergies: _____

Any serious illnesses in your immediate family: _____

Are you on a special diet? Yes /No **Do you drink**? Yes / No **Do you smoke**? Yes/ No **Do you exercise**? Yes/ No

NSAIDS: aspirin, motrin, diclofenac, advil, ibuprofen, naproxen **BLOOD THINNERS**: plavix, warfarin, coumadin
SLEEP aids: ambien, restoril, benadryl, halcyon
NEUROPATHIC PAIN MEDS: neurontin, tegretol, dilantin, baclofen, ultram, lyrica, prazocin
ANTIDEPRESSANTS: elavil, amitryptiline, prozac, effexor, zoloft, deseryl, paxil, parmetor
NARCOTICS: vicodin, darvocet, tylenol 3, codeine, percocet, percodan, MS contin, oxycontin, demerol, morphine, methadone, dilaudid
RELAXANTS: flexaril, valium, xanax, ativan, skelaxin

List All Medications: _____

_____

*Please list below any prior injury, medical/surgical treatment or procedure to your cervical, thoracic or lumbar spine with approximate dates:

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby affirm that the above information is true and accurate.

_____
Signature

_____
Print Name:

Dated: _____

REVIEW OF SYSTEMS

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N

Yes? Which Ones _____

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N

Endocrine

Excessive Thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N

Cardiovascular

Chest Pain	Y	N
Varicose veins	Y	N
High Blood Pressure	Y	N

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Rash	Y	N

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N

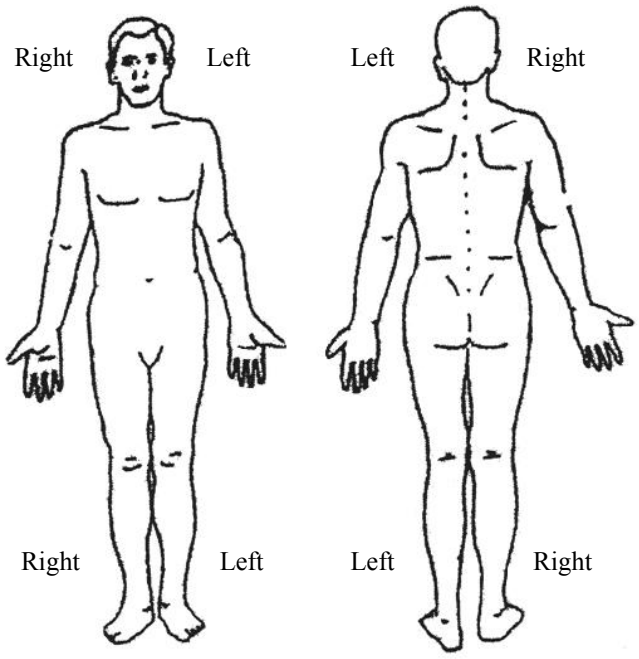
Hematologic/Lymphatic

Swollen Glands	Y	N
Blood Clot Problem	Y	N

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

On the diagram, please shade in the areas where you have pain:



NOTICE OF PATIENT PRIVACY (HIPPA)

By my signature below, I hereby acknowledge receipt of this Notice of Privacy Practices, and I acknowledge that the practice will use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting health care operations.

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations, Sebastian Lattuga, M.D., F.A.A.O.S. may need to disclose my health information to members of my family, doctors, insurance companies and lawyers.

If I am unavailable, I expressly permit Sebastian Lattuga, M.D., and his staff to disclose my health information for the purpose of appointment/test/ procedure reminders and follow-ups to the following individuals:

Name _____ Relationship to me

_____

_____

Signature: _____

Print Name: _____

Translators Signature: _____

Date: _____

Revised 03/01/2018

Heart - Do you have or ever had the following:

Suffer from high blood pressure?	Yes / No
Atrial fibrillation or irregular heartbeat?	Yes / No
High blood pressure or Mitral Valve Prolapse?	Yes / No
A heart attack, angina or chest pain?	Yes / No
High cholesterol?	Yes / No
A catheterization of your heart?	Yes / No
A heart stress test?	Yes / No
Chest pain or shortness of breath when climbing a flight of stairs?	Yes / No
Do you take antibiotics prior to a surgical procedure or dental work?	Yes / No

Treating physician name & phone: _____

Behavioral Health

Have you suffered from anxiety, depression or a psychiatric disorder? Yes / no

Treating Physician name & phone: _____

Communicable Disease:

Herpes: yes / no AIDS: yes / no

HIV: yes / no If yes, what was your last CD4 count & date: _____

Hepatitis: If yes, please circle - A, B, or C

Contact within the last month with anyone suspected of having any communicable disease? Yes / no

Have you traveled outside of the U.S. in the last month? If yes, where? _____

Breathing - Do you have or ever had the following:

Shortness of breath with exertion or swollen ankles?	Yes / no
Tuberculosis (TB)?	Yes / no
Smoked more than 1pk/day for 20yrs or 2pks/day for 10yrs?	Yes / no
Smoked in the last year?	Yes / no
Oxygen at home to help you breathe?	Yes / no
Severe emphysema, asthma or bronchitis (COPD) that limits your activities?	Yes / no
Have you been diagnosed or suspected to have Obstructive Sleep Apnea (OSA)?	Yes / no
Do you use a BiPAP or CPAP machine at home?	Yes / no
Did you ever have an embolus or clot go to your lung?	Yes / no

Blood disorders - Do you have or ever had the following:

Anemia or low blood count?	Yes / no
Bleeding ulcers or rectal bleeding	Yes / no
Sickle cell disease or trait?	Yes / no
Blood clots in your legs (phlebitis) or deep vein thrombosis (DVT)?	Yes / no
Do you use warfarin (Coumadin) as a blood thinner?	Yes / no
Do you bruise easily and/or have a bleeding problem/disorder?	Yes / no

Treating Physician name & phone: _____

Endocrine/renal disorders - Do you have or ever had the following:

Diabetes?	Yes / no
What was your last Hemoglobin A1C? _____ When was it done? _____	
Adrenal or thyroid disease or tumor?	Yes / no
Kidney disease, kidney failure or are you on dialysis?	Yes / no
Severe hepatitis, jaundice, cirrhosis or liver failure?	Yes / no
Do you use diuretics (water pills), digoxin (lanoxin) or steroids (prednisone)?	Yes / no

Treating physician name & phone: _____

Gastrointestinal - Do you have or ever had the following:

Severe abdominal pain?	Yes / no
Loss of appetite or unintentional weight loss in the past year?	Yes / no
Acid reflux?	Yes / no

Treating physician name & phone: _____

Obstetrics:

Are you or do you believe you might be pregnant? Yes / no Last menstrual cycle: _____

Cancer - Do you have or ever had the following:

Cancer and/or received chemotherapy?	Yes / no
Have you received radiation therapy?	Yes / no
An axillary lymph node dissection (under arm)	Yes / no