David K. Padgett, D.O.

PATIENT HISTORY AND

PHYSICAL

Physical Medicine and Rehabilitation
Osteopathic Manipulative Medicine
Electrodiagnostic Medicine & Sports Medicine

Date of first visit _____/_____/ ___

Patient Name: Last First Middle

Height	Weight	Birth Date
Feet: Inches:	# Pounds:	_____/_____/_____

INJURY/PAIN HISTORY

Reason for this visit: _____

Date of injury or first signs of pain? _____/_____/_____

Primary location of injury/pain? (specify on attached chart)

Cause of injury/pain? [] work [] leisure [] daily chores [] driving accident [] other _____

Specifics: _____

When do you most frequently feel discomfort or pain?

Time of day: [] morning [] afternoon [] evening [] night

Doing what activity: _____

What steps do you currently take to reduce this pain? Check all that you pursue and the order (1^{st} , 2^{nd} ,3^{rd} …) that you pursue: ____ medication ____ exercise ____ massage ____ chiropractor ____ physical therapy ____ meditation ____ other: details:

PAST MEDICAL HISTORY	**NA for Not applicable or provide details**	
Surgical Procedure(s)	Hospitalized?	Year
	[] Inpatient [] Out	
	[] Inpatient [] Out	
	[] Inpatient [] Out	
	[] Inpatient [] Out	
Other Illnesses (non-surgical)	Hospitalized?	Year
[] Diabetes		
[] Hypertension		
[] Cancer of:		
[] History of physical, sexual or emotional abuse		
[] Other		

Medication (including birth control pills, vitamins, aspirin)	**Y(es) N(o)**	**Dosage**	**Frequency**
Vitamins:			
Aspirin:			

Patient Name: Last: _____ **First:** _____ **Date of first visit** _____/_____/ ___

REVIEW of SYSTEMS

ALLERGIES: **[] No known allergies**

[] Iodine [] Aspirin [] Anesthetic [] Antibiotics [] Penicillin [] Sulfa

[] Food (type[s]) _____ [] other _____

Patient Name: Last: _____ **First:** _____ **Date of first visit** _____/_____/ _____

Difficulty with ~ Please check all that apply:

Condition/Disease	Experienced NO	Past	Recent	Condition/Disease	Experienced NO	Past	Recent
Headaches				**HEMATOLOGY**			
HEENT				Bleeding Disorders			
Vision				Anemia			
Hearing				**UROLOGY**			
Nose/Smell				Prostate Problems			
Mouth				Urinary Infection			
GI				Urine Stones			
Swallowing				Blood in urine			
Lymph Nodes				**RHEUMATOLOGY**			
PULMONARY				Arthritis			
Pneumonia				Joint Pain			
Bronchitis				Local Pain Point			
Asthma				Immune Disorder			
Emphysema				**CNS**			
Tuberculosis				Seizure Disorder			
CARDIOLOGY				Stroke			
Rheumatic Fever				Parkinson's Disease			
Heart Attack				**DERMATOLOGY**			
Angina				Rash			
Heart Murmur				Eczema			
Antibiotics prior to dental/minor procedure				Psoriasis			
Chest Pain				**GASTROENTEROLGY**			
Shortness of breath				Hepatitis/Jaundice			
Swelling in legs				Peptic Ulcer			
Cramps in legs w/exercise				Duodenal Ulcer			
ENDOCRINE				Gastric Ulcer			
Diabetes				Heartburn			
Bleeding Tendency				Gallstones			
Thyroid Problems				Constipation			
				Vomiting			
				Nausea			
				Diarrhea			
				Bloody/Black Stool			
				Diverticulosis			
				Diverticulitis			

Patient Name: Last: _____ **First:** _____ **Date of first visit** _____/_____/ ___

FAMILY HISTORY					
Family Member	Living (Y/N)	**Sex**	**Age**	Medical Problems (if any) especially if pertinent to your condition - Major Illness/Cause of Death	Date Deceased
Father					/ /
Mother					/ /
Sibling					/ /
Sibling					/ /
Sibling					/ /
Sibling					/ /
Children	**[] None, or**				/ /
Child					/ /
Child					/ /
Child					/ /
Child					/ /

Is there any family history of alcohol or drug addiction? (Circle) No. Yes. If yes, list who in your family and describe addiction: _____

_____

SOCIAL HISTORY

[] Married [] Single [] Divorced [] Widowed [] Other _____

Last grade of school attended _____

Do you:	**NO**	**If YES:**	**Quantity**
Work?		Occupation?	
Spouse work?		Occupation?	
Have exposure to chemicals?		Type?	
Have exposure to excess sun?			
Smoke?			Packs/day?
Spouse smoke?			Packs/day?
Alcohol?			Drinks/day?
Caffeine?			Drinks/day?
Drugs?		Type: [] Pot [] Cocaine [] Crack [] Other:	Frequency?
Exercise		Type:	Times/week?
Have you had a significant (more than 15 pounds) change in weight in last six months?		[] Gain of _____ pounds [] Loss of _____ pounds	
Do you feel SAFE in your home?	If NO, elaborate		

OTHER Information you think Dr. Padgett should know: _____

_____

_____