David K. Padgett, D.O.

PATIENT HISTORY AND

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

Electrodiagnostic Medicine & Sports Medicine	Date of first visit//			
Patient Name: Last	First	Middl	e	
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? (speci	-			
Cause of injury/pain? [] work [] leisure	e [] daily chores [] driving	; accident [] other		
Specifics:				
When do you most frequently feel disco	omfort or pain?			
Time of day: [] morning [] afternoon []				
Doing what activity:				
What steps do you currently take to red	uce this pain? Check all	that you pursue and the o	order $(1^{st}, 2^{nd}, 3^{rd})$	
that you pursue: medication	exercise massage _	chiropractor p	hysical therapy	
meditation other: details:				
PAST MEDICAL HISTORY		for Not applicable		
		provide details		
Surgical Procedure(s)		spitalized?	Year	
		npatient [] Out		
		npatient [] Out		
		npatient [] Out		
		npatient [] Out		
Other Illnesses (non-surgical)	Hos	spitalized?	Year	
[] Diabetes				
[] Hypertension				
[] Cancer of:				
[] History of physical, sexual or emotio	nal abuse			
[] Other				
Modization (naluding birth control wills with	oming agnirin) V(es) N(a)	Dosogo Ero		

Medication (including birth control pills, vitamins, aspirin)	$\mathbf{Y}(\mathbf{es}) \mathbf{N}(0)$	Dosage	Frequency
Vitamins:			
Aspirin:			

REVIEW of SYSTEMS ALLERGIES: [] No known allergics [] Iodine [] Ansthetic [] Antibiotics [] Penicillin [] Sulfa [] Food (type[s]) [] other [] Iodine [] Saprint [] Ansthetic [] 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 Past Recent Condition/Disease Experienced Past Recent NO Headaches Koperienced Past Recent Condition/Disease Experienced NO HEMATOLOGY PlumONARY Anther Notes System Disorder Condition Union PlumONARY Arther Notes Plant Wathor Docy Plant Meatonology P	Patient Name: Last:			I	First:	Date of f	ïrst visit	_/	_/
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Patient Name: Last:	First:	Date of first visit	/ /	/

FAMILY HISTORY						
Family	Living	Sex	Age	Medical Problems (if any) especially if pertinent to your	Date	
Member	(Y/N)			condition - Major Illness/Cause of Death	Deceas	sed
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

[] 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	Frequency?
		[] Other:	
Exercise		Туре:	Times/week?
Have you had a significant		[] Gain of pounds	
(more than 15 pounds) change		[] Loss of pounds	
in weight in last six months?			
Do you feel SAFE in your	If NO,		
home?	elaborate		

OTHER Information you think Dr. Padgett should know: