NORTH SHORE SHOULDER
New Patient History Form

Today's date____/____/____

1) **Name___________________________________** **Date of birth____/____/____**

2) **Name of Primary Care Physician** _________________________________

3) **What is the main reason for your visit today?** Please be specific (i.e. location of bodily complaints, right or left)
____
____
____

4) **How long have you had this problem?**______________________________________

5) **How did this problem begin?** Car Accident Work Injury Fall Lifting Sports
Other____

5) **What treatment have you had for your current problem?** Physical Therapy X-rays MRI
Chiropractic Care Medications (Please list____)
Other____

6) **Have you had this problem in the past or a previous injury to this same area of you body?**
No Yes ____

Past Medical History

Please list ALL the medications you are currently taking.
____
____
____
____
____
____
____
____
____
____

Please circle Y or N if applies to you
Y N Diabetes
Y N High blood pressure
Y N Cancer (________________)
Y N Asthma
Y N Stomach problems
Y N Thyroid problems
Y N Heart disease
Y N Sleep apnea
Y N Bleeding disorder
List other medical problems__________
____
____
____

10) **List ALL drug allergies:**____

11) **Height:** _________ **Weight:** ___________

12) **BP:**_______________

Family and Social History

13) List any surgeries and approximate dates or procedures________________________________
____
____

14) Occupation____

15) Activities____

16) Do you smoke? No Yes______Pk/Day **Do you drink Alchohol?** No Socially Daily

17) Do any medical problems run in your family? If so please list________________________
____

15) Are you RIGHT or LEFT **handed?**

16) Females: Last menstrual period____/____/____Are you currently pregnant? Yes No