GARRETT DAVIS, M.D.

HEALTH HISTORY **MRN**_____

Name_____**Date of Birth**_____**Age**_____
Occupation_____
Referring Physician _____**City/State of Referring Physician**_____
In your own words, what is (are) your specific concern(s)?

_____
_____
_____

Did you sustain an injury? ☐ **No** ☐ **Yes** **Date of Injury?** _____
Was it work related? ☐ **No** ☐ **Yes**
If work related, what is your current work status?_____
If not work related, during what activity? _____
How many reinjuries? _____

PRESENT/PAST MEDICAL HISTORY (please check all that apply):

☐ Heart disease	☐ Prostate disease	☐ Liver disease
☐ Cervical spine disorder	☐ Bowel disease	☐ Nerve impairment
☐ Seizures	☐ Severe headaches	☐ Severe headaches
☐ Tuberculosis/TB	☐ Muscle disease	☐ Mental health problem
☐ Depression	☐ Chronic skin disease	☐ Sleep apnea
☐ High blood pressure	☐ High cholesterol	☐ Asthma
☐ Diabetes	☐ Hypoglycemia (low glucose)	☐ Thyroid disease
☐ Stomach disease	☐ Kidney disease	☐ Bladder disease
☐ Blood clots/DVT	☐ Pulmonary Embolism	☐ Bleeding tendency
☐ Lumbar spine disorder	☐ Anemia or other blood disease	

☐ Cancer – Type:_____Dates:_____
Treatment: Chemotherapy Radiation Surgery All
Remission: Y N

HOSPITALIZATIONS OTHER THAN SURGERIES (last 10 years): **None**

Approximate Date	Purpose
_____	_____
_____	_____
_____	_____

ORTHOPEDIC/NEUROLOGIC SURGERIES, FRACTURES (last 10 years): **None**

JOINT REPLACEMENT Hip Knee Shoulder R L Both
Dates:_____

ARTHROSCOPY Hip Knee Shoulder R L Both
Dates:_____

SPINE SURGERY: Type _____
Dates:_____

OTHER TYPES:_____
Dates:_____

FRACTURES: Body Part_____
Treatment_____
Dates:_____

OTHER PAST SURGERIES: None

HEART BYPASS	HEART VALVE REPLACEMENT	GALL BLADDDER
APPENDIX	ORGAN TRANSPLANT	COSMETIC

OTHER:_____
DATES:_____

CURRENT MEDICATIONS (includes non-prescription products): **None**

	Drug	Dose	Frequency		Drug	Dose	Frequency
1.				2.			
3.				4.			
5.				6.			

ALLERGY TO MEDICATION: None
If yes, which ones_____Type of reaction_____

PERTINENT FAMILY MEDICAL HISTORY (cancer, heart disease, hypertension, etc):

_____

SPECIAL CONSIDERATIONS: None

☐ Legally blind ☐ Hearing impaired ☐ Need handicap facilities
☐ Pregnant ☐ Attempting pregnancy ☐ Adverse reaction to anesthesia
☐ Tobacco use: Y N Packs/day_____
☐ Alcohol use: Y N Drinks /week_____
☐ Recreational Drug use: Y N Type:_____Frequency_____

ACTIVITY LEVEL: None

☐ Competitive athlete ☐ Well-trained/frequent sports ☐ Occasional sports

What would you like your physician/team to accomplish today?

☐ Accurate diagnosis ☐ Medication ☐ Surgery plan if necessary
☐ Healthy exercise plan ☐ Nutritional plan ☐ Physical therapy plan
☐ Alternative therapy plan (may include acupuncture, massage, manipulation)
☐ Disability info ☐ Other _____

PATIENT SIGNATURE _____ **DATE**_____

PARENT/GUARDIAN_____ **DATE**_____