John L. Albrigo, M.D.

PATIENT MEDICAL HISTORY FORM

Date completed: _____________ Name: ________________________________ Age: ____________ Sex: M F

Height: __________ Weight: ___________ Are you right handed? ___________ Left handed? _______________

For office use only: Respirations: _______________ Vitals: ____

Referring Physician (name and phone number): ____

Present Complaint: Rt/Lt (indicate body part) ____

____

Date of Onset: ___________________ Injury Related: ( ) Yes ( ) No Work Related: ( ) Yes ( ) No

List activities that make it worse:____

Previous treatment (therapy, injections, medications): ____

____ When: ____________________________________

Treating Physician (name and phone number): ____

Review of Systems:

Weight Loss	( ) Y	( ) N	Poor Vision	( ) Y	( ) N	Tingling	( ) Y	( ) N	Vertigo	( ) Y	( ) N
Weight Gain	( ) Y	( ) N	Hearing Loss	( ) Y	( ) N	Tremors	( ) Y	( ) N	Weak Muscles	( ) Y	( ) N
Fatigue	( ) Y	( ) N	Ringing in Ears	( ) Y	( ) N	Rashes	( ) Y	( ) N	Joint Stiffness	( ) Y	( ) N
Fever	( ) Y	( ) N	Upset Stomach	( ) Y	( ) N	Open Sores	( ) Y	( ) N	Back Pain	( ) Y	( ) N
Chills	( ) Y	( ) N	Constipation	( ) Y	( ) N	Excessive Thirst	( ) Y	( ) N	Other:		
Cough	( ) Y	( ) N	Bloody Stools	( ) Y	( ) N	Frequent Urination	( ) Y	( ) N	__________________________		
Breath Shortness	( ) Y	( ) N	Diarrhea	( ) Y	( ) N	Painful Urination	( ) Y	( ) N	__________________________		
Chest Pain	( ) Y	( ) N	Easy Bruising	( ) Y	( ) N	Hair Loss	( ) Y	( ) N	Other Joint Pain:		
Palpitations	( ) Y	( ) N	Easy Bleeding	( ) Y	( ) N	Mood Swings	( ) Y	( ) N	__________________________		
Leg swelling	( ) Y	( ) N	Poor Balance	( ) Y	( ) N	Anxiety	( ) Y	( ) N	__________________________		
Blurred Vision	( ) Y	( ) N	Numbness	( ) Y	( ) N	Depression	( ) Y	( ) N			

Medications, Vitamins or Supplements & Dosages: ( ) None

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Allergies to Medications: (__) None:

____

____

Other Allergies: Metal, Iodine, Shellfish

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***IF YOU HAVE A LIST OF YOUR MEDICATIONS WE WILL GLADLY MAKE A COPY**

Social History:

Do you smoke? ( ) Yes ( ) No If yes, __________ packs per day for ______ years

Have you ever smoked in your life ( ) Yes ( ) No. If Yes, when did you quit? ____________________________

Do you drink alcohol? ( ) Yes ( ) No If yes, how much? ____

Occupation: ____

Where do you live: (Circle One) Home Apartment Retirement Community

Who do you live with: ____

Reviewed by Provider: _________________________________ Date:____________________________________

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Family History: Is there any family history of: (Circle): **( ) None**
Stroke Heart Disease Diabetes Cancer Arthritis Other: ______________________________

If Yes, Please explain: ____

Past Medical History: Do you have currently or have you ever had?

Anemia	( ) Y	( ) N	Elevated cholesterol	( ) Y	( ) N	Liver Disease/Hepatitis	( ) Y	( ) N
Angina	( ) Y	( ) N	Emphysema/COPD	( ) Y	( ) N	Pancreatitis	( ) Y	( ) N
Asthma	( ) Y	( ) N	Epilepsy	( ) Y	( ) N	Pneumonia	( ) Y	( ) N
Atrial Fibrillation	( ) Y	( ) N	Fractures	( ) Y	( ) N	Hiatal Hernia/Reflux	( ) Y	( ) N
Bladder Infection	( ) Y	( ) N	Glaucoma	( ) Y	( ) N	Sinus Problems	( ) Y	( ) N
Bronchitis	( ) Y	( ) N	Gout	( ) Y	( ) N	Sleep Apnea	( ) Y	( ) N
Cancer	( ) Y	( ) N	Heart Attack	( ) Y	( ) N	Stomach Ulcers	( ) Y	( ) N
Cellulites	( ) Y	( ) N	Heart Arrhythmia	( ) Y	( ) N	Stroke	( ) Y	( ) N
Congestive Heart Failure	( ) Y	( ) N	Heart Valve Disease	( ) Y	( ) N	Thyroid Disorders	( ) Y	( ) N
Coronary Artery Disease	( ) Y	( ) N	High Blood Pressure	( ) Y	( ) N	TIA	( ) Y	( ) N
Depression	( ) Y	( ) N	HIV	( ) Y	( ) N	Blood clots	( ) Y	( ) N
Diabetes	( ) Y	( ) N	Kidney Disease	( ) Y	( ) N	Osteoarthritis	( ) Y	( ) N
Dialysis	( ) Y	( ) N	Kidney Stones	( ) Y	( ) N	Rheumatoid Arthritis	( ) Y	( ) N
Diverticulitis	( ) Y	( ) N	Leukemia	( ) Y	( ) N	Osteoporosis	( ) Y	( ) N

Other: ____

Past Surgical History: Please mark all previous surgeries: **( ) None**
( ) C-Section ( ) Cataract surgery ( ) Hernia repair ( ) Hysterectomy ( ) Pacemaker ( ) Tonsils ( ) Gall bladder
( ) TURP ( ) Appendectomy ( ) Arthroscopy ( ) Thyroid ( ) Mastectomy ( ) Hip pinning ( ) Cosmetic surgery
( ) Right total knee replacement ( ) Left total knee replacement ( ) Repeat Right knee replacement ( ) Repeat Left total knee replacement ( ) Right partial knee replacement ( ) Left partial knee replacement ( ) Right total hip replacement ( ) Left total hip replacement ( ) Repeat Right total hip replacement ( ) Repeat Left hip replacement
Other surgery:

Problems with anesthesia: ( ) Yes ( ) No Explain: ______________________________
Problems with Foley/Bladder catheter: ( ) Yes ( ) No Explain:______________________________

Elaborate on medical history/medications if necessary (use separate sheet if necessary):

Primary Care Physician: (name, address, and phone number) ______________________________

Reviewed by Provider: ______________________ Date:______________________
Form last updated: 1/27/14 (ydc)

JOHN L. ALBRIGO

COMPARATIVE PAIN SCALE

PLEASE CIRCLE THE ONE THAT APPLIES

0
No Hurt

1
Hurts
Little Bit

2
Hurts
Little More

3
Hurts
Even More

4
Hurts
Whole Lot

5
Hurts
Worst