ATHENS PHYSICAL THERAPY
ATHENS NEURO AND BALANCE REHABILITATION
PHYSICIANS BACK AND NECK CLINIC
BETTER BONE CLINIC
CHRISTOPHER E. DOERR, D.O., P.C.

Today's Date: _____

GENERAL MEDICAL HISTORY FORM

Patient Name_____ Date of Birth_____ Social Security #_____

Age_____ Male/Female Height___'_____" Weight_____lbs Right / Left Handed

Name of Referring Physician_____ Primary Care Physician_____

***My signature below confirms that the information provided on this document is accurate to the best of my knowledge*.**

Patient Signature: _____

Parent/Guardian's Signature: _____

DEMOGRAPHIC DATA

LANGUAGE	**RACE**	**ETHNICITY**	**EMAIL ADDRESS**
□ English □ Spanish □ Other □ Declined	□ American Indian/Alaska Native □ Black/African American □ Native Hawaiian/other Pacific Islander □ White □ Asian □ Other Race □ Declined to Specify	□ Hispanic Origin (Spanish) □ Non- Hispanic Origin □ Declined to Specify	By providing your email address you are consenting to use of the Patient Portal

PREFERRED PHARMACY

Pharmacy name	Address/Location	Phone number	Your signature and Date

MEDICATIONS

LIST ALL MEDICATIONS CURRENTLY TAKEN INCLUDING OVER-THE-COUNTER / HERBAL / DIET SUPPLEMENTS

	Name	Strength (mg)	Times per day
1			
2			
3			
4			
5			
6			
7			
8			

(Continue medication list on next page)

Patient Name_____ Date of Birth_____

Continued medication list:

	Name	Strength (mg)	Times per day
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

ALLERGIES

Please list any medications you are allergic to and type of reaction: _____

_____

Are you allergic to anything else? □ NO □ YES_____

PAST MEDICAL HISTORY

PLEASE CHECK ALL THE SURGERIES AND PROCEDURES YOU HAVE HAD:

□ Appendectomy	□ Hernia (hiatal, abdomen or groin)	□ Hysterectomy
□ Cholecystectomy (gallbladder removal)	□ Breast implants or reduction surgery	□ Cardiac catherization □ Kyphoplasty
□ Metal implants	□ C-section	□ Bone density test (DXA scan)
□ Exercise stress test	□ Heart Surgery	□ Pacemaker
□ Back or neck surgery Specify:	□ Joint replacement Specify:	□ Gastric bypass or sleeve □ Other surgery

Patient Name_____ Date of Birth_____

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

□ Acid reflux or Hiatal hernia	□ Fractures type:_____ _____	□ Migraine Headache	
□ Anemia		□ Multiple Sclerosis	
□ Arthritis (choose below) __ wear and tear (osteoarthritis) __ autoimmune (rheumatoid, lupus, psoriatic)	□ GERD (reflux)	□ Osteopenia	Date of latest DXA:
	□ Gluten sensitivity	□ Osteoporosis	
□ Asthma	□ Gout		
□ Balance problem	□ Heart Attack/Disease	□ Paget's Disease/Rickets/ Osteomalacia	
□ Bladder problems	□ High Blood Pressure	□ Parkinson's Disease	
□ Bleeding/bruising disorder	□ Hyperparathyroidism	□ Prostate problems	
□ Blood clots in legs or lungs	□ Hyperthyroidism (overactive thyroid)	□ Psychological problems	
□ Brain injury	□ Hypothyroidism (low thyroid)	□ Seizures	
□ Cancer type:_____	□ Hypoglycemia (low blood sugar)	□ Spinal Cord injury	
□ Carpal Tunnel Syndrome	□ Inflammatory Bowel/ Malabsorption disease	□ Stomach Ulcer	
□ Chronic Lung disease	□ Irregular Heartbeat	□ Stroke/TIA	
□ Depression	□ Irritable Bowel syndrome	□ TMJ	
□ Diabetes (choose below) ___ Type I ___ Type II	□ Kidney problems	□ Tuberculosis	
□ Elevated Cholesterol	□ Kidney stones	□ Vertigo	
□ Epilepsy/seizures	□ Low Blood Pressure	□ Vitamin D deficiency	
□ Fibromyalgia	□ Menopausal		

Patient Name_____ Date of Birth_____

REVIEW OF SYSTEMS

CHECK IF YOU HAVE A HISTORY OF:

□ Bleeding tendencies	□ Wheezing
□ Swollen lymph nodes	□ Frequent cough (once a day or more)
□ Sleeping problems	□ Coughing up phlegm or mucus daily
□ Urine leakage	□ Profuse sweating at night
□ Change in stool color	□ Frequent vomiting
□ Frequent urination at night	□ Balance problems
□ Problems with memory/concentration	□ Hard of Hearing
□ Blood in urine	□ Coordination problems
□ Shortness of breath at rest	□ Blurred or Double vision
□ Shortness of breath with little exertion	□ Joint pain/swelling (other than your spine)
□ Shortness of breath while lying flat	□ Muscle pain/spasm
□ Swelling of the feet, ankles and/or legs	□ Numbness/tingling of hand, arm, leg or foot
□ Leg pain with prolonged walking	□ Weakness of leg or arm
□ Recent fractures	□ If you are female, any chance you are pregnant?
□ Rash	□ Sensitivity to chemicals
□ Excessively tired	□ Ringing in your ears
□ Bowel or bladder abnormalities	□ Frequent headache
□ Diarrhea	□ Dizziness
□ Constipation	□ Emotionally traumatic event
□ Pelvic pain	□ Anxiety attacks
□ Hyperventilating spells	□ Weight gain of _____ pounds in last 6 months
□ Females: painful menstrual periods	□ Weight loss of _____ pounds in last 6 months

Is there any information that is not already included in this form that you feel is important for us to know regarding your health?

_____

_____

FAMILY HISTORY

ARE THERE ANY DISEASES THAT RUN IN YOUR FAMILY? PLEASE LIST HEALTH PROBLEMS OR CAUSE OF DEATH

Father	Age
Mother	Age
Sibling	Age
Sibling	Age
Sibling	Age

Revised June 5, 2020

Patient Name_____ Date of Birth_____

SOCIAL HISTORY

CURRENT WORK STATUS:

Working:	□ YES □ NO □ RETIRED	Current or Previous Occupation:
Disabled:	□YES □NO	Reason for disability:
Medical Leave	□ YES □NO	Who took you out of work?
		Last Day Worked?

CURRENT MARITAL STATUS:

□ Single □ Married/Partnered □ Divorced □ Widowed

What is the name of your spouse/partner?_____

DOES YOUR HOME HAVE ANY OF THE FOLLOWING?

□ Stairs without railing □ Stairs with railing □ Ramps
□ Uneven terrain or obstacles □ Assistive devices □ Elevator

WITH WHOM DO YOU LIVE?

□ Alone □ Spouse/Partner □ Children □ Parents Other:

DO YOU HAVE CHILDREN? □ NO □ YES Ages_____

DO YOU SMOKE? □ NO, *never* | □ NO, *but I used to* □ YES Year **started**:_____ Year **quit**: _____

Form of tobacco? _____ Packs/day? _____ Are you interested in quitting? □ NO □ YES

DO YOU DRINK ALCOHOL? □NO, never □ NO, but I used to □ YES

If YES, how often and how much? □ Daily □ Weekly □Monthly □ Yearly Number of drinks _____

DO YOU USE RECREATIONAL DRUGS? □ NO □ YES If yes, what substance(s)_____

DO YOU FEEL YOU ARE DEPENDENT ON DRUGS OR ALCOHOL? □NO □YES

DO YOU EXERCISE REGULARLY? □ NO □ YES _____times per week Type of exercise_____

HAVE YOU HAD A FLU SHOT IN THE LAST 12 MONTHS? □ YES □ NO

IF OVER 65 YRS OLD, HAVE YOU HAD THE PNEUMOCOCCAL VACCINE? □ YES □ NO

Revised June 5, 2020