Barry A. Nelms, M.D., P.A.
PATIENT MEDICAL HISTORY

Patient Name: ______________________________ Birth Date: _____________ Sex : ☐ M ☐ F

Today's Date: ____________ Date of Injury: ____________ Are You? ☐ Right-Handed ☐ Left-Handed

Occupation: ______________ Primary Care Physician: ____________________ Phone #: _____________

How were you referred to our office? ☐ Dr ☐ Insurance ☐ Relative/Friend ☐ On-Line ☐ W/C

Referring Physician's Name: ____________________________________ Phone#: ________________
Physician's Address: __________________________ City/State: _____________________________

Is this work related? ☐ Yes ☐ No Was it reported? ☐ Yes ☐ No

HISTORY OF PRESENT ILLNESS:
Ht: ______ **Wt:** ______ **lbs. B/P:** _____

CC/Why are you here today? ____

Location: ______________________________
Where is the pain/problem? Does it travel to other areas

Quality: ______________________________
Is the pain dull, throbbing, sharp? If lump, is it warm, tender, red?

Severity: ______________________________
How severe is the pain on a scale of 1-10 with 10 most severe

Duration: ______________________________
How long have you had this problem? When did it start?

Timing: ______________________________
Does the pain occur at a specific time? Rare, Intermittent or Constant

Context: ______________________________
What are you doing at the onset of the problem?

Associated signs/symptoms: ____
What other associated problems (numbness, tingling, pain at night, bladder/bowel, cracking, popping, grinding, clicking, swelling, stiffness, instability)

Modifying Factors: ____
What makes the pain/problem worse / better (example: medication, rest, exercise, bending, stooping, lifting, climbing)

Which activities are you unable to perform due to your pain? ________________________________

Have you seen any other physicians regarding **this** condition prior to coming to our office? ☐ Yes ☐ No

Doctor	When	Tests	Results	Treatment

PAST HISTORY OF PRESENT ILLNESS:
Have you ever experienced any injury or symptoms regarding this body part: ☐ Yes ☐ No

If so, please provide details:

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