Name:_____

Patient History
Dr. Andrew Jeffers

Date: 10/6/2022

Please answer the questions to the best of your ability.

Pain History

Do you have pain? ☐ Yes ☐ No

Please rate your pain from 1 to 10, with 10 as the worst pain.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Please describe your pain. Select all that apply:

☐ Sharp ☐ Stabbing ☐ Achy ☐ Burning ☐ Dull ☐ Shock-like ☐ Throbbing

When do you experience your pain? Select all that apply.

☐ Constantly ☐ Randomly ☐ With motion ☐ With activity ☐ During the day ☐ At night

What makes the pain better? Select all that apply.

☐ Nothing ☐ Rest ☐ Medications ☐ Ice ☐ Heat ☐ Massage

Approximately how long ago did the pain start? Please select a number followed by either days, weeks, months or years.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11

☐ days ☐ weeks ☐ months ☐ years

Social History

Smoking status: Do you smoke or use tobacco products? Choose one answer.

☐ nonsmoker (never smoked) ☐ former smoker (quit) ☐ active smoker/user

Do you drink alcohol? ☐ Yes ☐ No

If Yes: How much alcohol do you drink?

☐ 1-11 drinks/year (fewer than one/month) ☐ 1-3 drinks/month (fewer than one/week)

☐ 1-6 drinks/week ☐ 1 drink every day ☐ More than 1 drink every day

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Choose not to answer

Family History

Please indicate if your mother or father have any of the following medical problems. Select all that apply.

Father

☐ No Medical Problems ☐ Bleeding Problems ☐ Clotting Problems ☐ Anesthetic Problems

☐ Heart Problems ☐ Lung Problems ☐ Kidney Problems ☐ Cancer

Mother

☐ No Medical Problems ☐ Bleeding Problems ☐ Clotting Problems ☐ Anesthetic Problems

☐ Heart Problems ☐ Lung Problems ☐ Kidney Problems ☐ Cancer

Name:_____

Patient History
Dr. Andrew Jeffers

Date: 10/6/2022

Select any medical problems you may have. You can list any other problems in the box below.

Past Medical History
Please mark if you have or had any of the following medical problems.

☐ Mark here if you have **no** medical problems

☐	Coronary Artery Disease	☐	Deep Vein Thrombosis (DVT)
☐	History of Heart Attack	☐	Pulmonary Embolism
☐	Hypertension	☐	Kidney Failure
☐	Hypercholesterolemia	☐	Stroke
☐	Diabetes	☐	Seizures
☐	Hypothyroidism	☐	Anxiety
☐	Sleep Apnea	☐	Depression
☐	Stomach Ulcer	☐	Cancer (please list the type below)

List any other medical problems that you have, including any types of cancers. Ask the secretary if you need another page.

Review of Systems
Mark Yes or No if you have any of the following conditions. Please be as complete as possible.

Are you feeling sick?	☐	Yes	☐	No
Have you had any recent fevers?	☐	Yes	☐	No
Do you have shortness of breath?	☐	Yes	☐	No
Have you had a recent cough?	☐	Yes	☐	No
Do you have chest pain at rest?	☐	Yes	☐	No
Do you have an irregular heartbeat?	☐	Yes	☐	No
Have you had any recent unexplained abdominal pain?	☐	Yes	☐	No
Do you ever have blood in your stool?	☐	Yes	☐	No
Do you often get urinary tract infections (UTIs)?	☐	Yes	☐	No
Do you bleed easily?	☐	Yes	☐	No
Do you faint easily?	☐	Yes	☐	No
Do your legs often cramp?	☐	Yes	☐	No

Name:_____

Patient History
Dr. Andrew Jeffers

Date: 10/6/2022

Please list the names of the medications you take. Ask the secretary if you need another page.

☐ Mark here if you are not taking any medications.

Please list any medication allergies you may have. Ask the secretary if you need another page.

☐ Mark here if you do not have any allergies to medications.

☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Aspirin ☐ Nickel ☐ Ibuprofen (NSAIDS)

Please list any surgeries you have had. Ask the secretary if you need another page.

☐ Mark here if you have not had any surgeries.