Name:
Date:

Thomas Youm, MD
1056 Fifth Ave, NY, NY 10028

PATIENT HISTORY

Age_____ DOB_____Occupation_____ Referred by _____

Height_____Weight____ Eyes____Hair____ *Handed:* R L *Sex:* M F *Race:* Wh Bl Hisp Asian

Chief Complaint *(main problem)*_____

_____

History Present Illness *Injury/Accident: Y or N* *Date of Injury:*_____

_____

_____

_____

_____

_____

_____

_____

Location of pain (ant, post, med, lat)_____Where does it travel_____

Pain for how long?_____ Pain on a scale of 1-10_____

Is the pain: Constant___ Intermittent___ Sharp___ Dull___ At Night___Other_____

Symptoms: Numbness/Tingling___ Locking__Giving way___ Swelling__ Other_____

What makes the pain *better*?_____*worse*?_____

What treatments have you tried? Nothing___ Pain: *improving*___ *worsening*___ *same*____

Medications(names, improvement?)_____

PT(#weeks, improvement?)_____

Injections(dates, location, types, improvement?)_____

Other/Surgery (improvement?)_____

_____

Studies? *Xrays* _____*MRI*_____ *CT Scan*_____ *EMG*_____ *Other*_____

(When?Results?)_____

_____

_____

Review of Systems: Have you had any of the following recently? Fever or Chills__ Blurred Vision____ Shortness of Breath__ Sore Throat__Chest Pain__ Nausea/Vomiting __Painful Urination__ Rashes___ Easy Bleeding/Bruising__ Seizures__ Headaches__ Weight Loss __

If so, explain:_____

Allergies_____***Drug Allergies***_____***Tolerate NSAIDs***? Y N

Social Hx: Tobacco (former, current, how many a day for how many years)_____

Alcohol (drinks/wk)_____ Drugs_____ ***Pregnant***: Y N ***Marital Status***: S M D W

Sports/Activities_____

Family History: DIABETES HEART DISEASE CANCER HYPERTENSION STROKE

If parent(s) deceased, underlying condition? Mother_____ Father_____

Medical Hx*:* HEART LUNGS STOMACH LIVER KIDNEY BLADDER DIABETES HTN

Sleep Apnea _____ Cardiac Stent _____ Blood Clot ____ Coumadin/Aspirin/Plavix _____

Explain:_____

Prior Surgeries w/ dates_____

_____

_____

Medications_____

_____

_____

Preferred Pharmacy (Name, Address, Zip, Ph#)_____

*Signature of Patient*_____ *Date*_____

Notes:

*Signature of Doctor*_____*Date*____ _____