

Patient History Form for Dr. Robert Burger

Patient Name (print): _____ Date of Birth: _____

Gender: Male Female

Marital Status: Single Married Divorced Widowed

Referred to Dr. Burger by: Self Family Physician Attorney Other: _____

Name of Person(s) making referral: _____

Reason for your visit today? (Check all that apply) Pain Weakness Loss of motion Other

Reason for visit (Body part): _____ Right Left Both

How did your symptoms start? _____

When did your symptoms start? _____

Is this a new (acute) injury? Yes No

Is this an old (chronic) condition? Yes No

Is this a sports related injury? Yes No

If yes, list School & Sport(s) _____

Is this a work related injury? Yes No

Is this a result of a motor vehicle accident? Yes No

On a scale from 0-10 how would you rate your pain level? (Circle answer):

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Most Severe)

Please Circle the following which best describes the nature of your pain (circle all that apply)

Sharp Dull Stabbing Throbbing Aching Burning Other: _____

Please circle the timing of your symptoms (circle all that apply):

Constant Intermittent (Comes and Goes) Pain only with activities Pain wakes you from sleep

Please circle any associated symptoms you have experienced (circle all that apply):

Swelling Stiffness Instability Giving Way Numbness Tingling Popping Clicking Catching

What makes symptoms better? _____

What makes symptoms worse? _____

Has this condition been evaluated by a Doctor? Yes No If yes, who and when: _____

What has been done for this condition?(circle all that apply):

Medications Rest Ice Heat X-rays MRI CT Physical Therapy Injection(s)

PLEASE CHECK IF YOU HAVE EVER HAD ANY OF THE SYMPTOMS LISTED BELOW:

Constitutional:

- Fever
- Weight loss
- Fatigue
- Weakness
- Dizziness

Gastro-Intestinal:

- Ulcer
- Frequent heartburn
- Reflux
- GI Bleeding

Urinary:

- Prostrate problems
- Kidney Stones
- Chronic infections
- frequent urination

Cardiovascular:

- Chest Pain or angina
- Shortness of breath
- Heart murmur
- Heart attack
- Irregular heartbeat
- Fainting or syncope

Ankle swelling

- Ankle swelling
- Rheumatic fever

Surgical:

- Anesthesia problems
- Wound healing problems

Psychological:

- Depression
- Anxiety disorder
- Memory problems

Respiratory:

- Asthma
- COPD
- Lung disease
- Pneumonia
- Tuberculosis

Hematologic:

- Anemia
- Poor Circulation
- Phlebitis
- Blood clots
- Excessive bleeding
- Blood transfusion

Allergy/Immune:

- Seasonal Allergies
- Skin conditions

Musculoskeletal:

- Joint pain
- Joint swelling
- Muscle weakness
- Muscle tenderness
- Muscle spasms
- Morning stiffness
- Rheumatoid arthritis
- Osteoporosis
- Gout

Neurological and ENT:

- Seizures or epilepsy
- Stroke or TIA
- Headaches
- Trembling or Tremor
- Balance problems
- Hearing or vision loss

PLEASE CIRCLE ANY OF THE FOLLOWING YOU ARE OR HAVE BEEN TREATED FOR:

- | | | | |
|-------------|---------------------|---------------|----------------------------|
| AIDS/HIV | COPD | Depression | Hepatitis |
| Alcoholism | Colon Cancer | Diabetes | Kidney Disease |
| Alzheimer's | Lung Cancer | Drug Abuse | Osteoarthritis |
| Anemia | Breast Cancer | Gout | Seizures |
| Asthma | Prostate Cancer | Heart Disease | Ulcers |
| Blood Clots | Cancer (type) _____ | Hypertension | Osteopenia or Osteoporosis |

Please list any other medical conditions we should be aware of: _____

Who is your Medical Doctor? _____

What is your current height? _____ **What is your current weight?** _____

Do you have any allergies to medication? Yes No **If yes, list medication(s) and reaction:** _____

List any previous surgeries or overnight hospital stays (Please include year): _____

**PLEASE CIRCLE THE FOLLOWING CONDITIONS YOUR IMMEDIATE FAMILY
(MOTHER, FATHER OR SIBLINGS) HAVE BEEN TREATED FOR:**

- | | | | |
|-------------|---------------------|---------------|----------------------------|
| AIDS/HIV | COPD | Depression | Hepatitis |
| Alcoholism | Colon Cancer | Diabetes | Kidney Disease |
| Alzheimer's | Lung Cancer | Drug Abuse | Osteoarthritis |
| Anemia | Breast Cancer | Gout | Seizures |
| Asthma | Prostate Cancer | Heart Disease | Ulcers |
| Blood Clots | Cancer (type) _____ | Hypertension | Osteopenia or Osteoporosis |

List any other conditions: _____

Which hand do you write with? Right Left **Are you retired?** Yes No

What is your occupation or job title? _____

Are you currently employed? Yes No **Who is your employer?** _____

Circle the best description of your previous education (circle one):

Graduate School College graduate Some college HS Graduate GED Technical Training

Do you use tobacco? Yes No Former **If yes, which type?** Chewing Cigar Cigarettes Pipe

Please list amount and duration: (example 1 pack a day for 20 years) _____

Do you consume alcohol? Yes No Former: **Do you consume caffeine?** Yes No

Please list amount and duration: (example 2 sodas a day or alcohol socially) _____

How would you describe your activity level? (Circle one): Above average Average Sedentary

How frequently do you exercise? (Circle one)

2-3 times/week 3-4 times/week 5 times/week Daily Never Occasionally

Which physical activities or sports are you involved with? _____

Please list your hobbies or activities: _____

Please list any additional information which you think we might need to know to provide you with the best care possible: _____

Patient signature: _____ **Date:** _____

Physician signature: _____