Stephen Mikulak, M.D.

Initial Visit History

Patient Name:_____ Date of Birth:_____ Age:_____ Date:_____

Height:_____ Weight:_____ Dominance: ☐ right ☐ left Marital status: ☐ M ☐ S ☐ W ☐ D

Occupation:_____ Referred by:_____

Pharmacy (include city and cross streets or phone number): _____

History of Present Condition

Body part:_____ When did the problem begin:_____

Did you have an accident/injury: ☐ yes ☐ no If yes, please explain:_____

_____

Please check the applicable symptom(s):

Quality of pain: ☐ sharp ☐ dull ☐ throbbing ☐ aching ☐ shooting ☐ burning

Severity of pain: ☐ minor ☐ moderate ☐ severe Pain Scale 0 – 10:_____

Any of the following symptoms: ☐ catching ☐ locking ☐ giving way ☐ none

Duration: ☐ intermittent ☐ constant lasting: ☐ minutes ☐ hours ☐ days

Context: ☐ worsening ☐ plateaued ☐ improving

Time: ☐ with certain activities ☐ at night ☐ other:_____

Associated signs/symptoms: ☐ bruising ☐ numbness ☐ weakness ☐ tingling

Do you currently have pain with walking: ☐ yes ☐ no ☐ occasionally

How far can you walk without stopping (blocks/miles/unlimited):_____

Do you use any aids: ☐ cane ☐ crutches ☐ walker ☐ wheelchair ☐ walking stick ☐ none

Do you currently have pain sitting: ☐ yes ☐ no ☐ occasionally

Do you have pain rising from a seated position: ☐ yes ☐ no ☐ occasionally

Do you use your hands to rise: ☐ yes ☐ no ☐ occasionally

How do you go up and down stairs: ☐ one foot per step ☐ two feet per step ☐ sideways ☐ sitting down ☐ backwards

Do you use a hand rail: ☐ yes ☐ no ☐ occasionally ☐ other: _____

Can you put your shoes and socks on: ☐ easily ☐ with difficulty ☐ with assistance ☐ someone else does it for you

Do you take any medications for this condition (including over the counter):_____

Have you had any treatment for the current condition (surgery/injections/physical therapy/etc.) ☐ yes ☐ no

If yes, please list the type and date:_____

What factors make your condition worse:_____

What factors make your condition better: ☐ ice ☐ rest ☐ elevation ☐ medications ☐ therapy ☐ massage ☐ heat ☐ other:_____

Medical History

Review of systems

Do you have or have had any of the following? If so please check, describe briefly and list when it occurred or if active.

☐ Sinus / Mouth / Ear Infections	☐ Bone / Joint / Muscle Pains	☐ Skin / Eyes Turn Yellow	
☐ Urinary Incontinence	☐ Shortness of Breath	☐ Frequent Infections	
☐ Taking Hormones	☐ Low Blood Count	☐ Easy Bruising	
☐ Menopause	☐ Fainting Spells	☐ Birth Marks	☐ Depression
☐ Blood Clots	☐ Numbness	☐ Weakness	☐ Dentures
☐ Dizziness	☐ Bleeding	☐ Anxiety	☐ Ulcers
☐ Fever	☐ Scars	☐ Burns	☐ Chills

Describe:_____

Past Medical History

List all past and present medical problems (include surgeries and hospitalizations, physician and year):

1. _____ →
2. _____ →
3. _____ →
4. _____ →
5. _____ →
6. _____ →
7. _____ →
8. _____ →

Medications

List current medication, dosage, and direction next to the medical problem you take it for:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergies

List allergies (including metal):

1. _____ →
2. _____ →
3. _____ →
4. _____ →
5. _____ →
6. _____ →

Allergy Reaction

Describe reaction next to the allergy listed (example: rash)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Family History (list relationship)

Hereditary disorders:_____ Cancer:_____

Heart disease:_____ Diabetes:_____

High blood pressure:_____ Lung Disease:_____

Kidney disease:_____ Other:_____

Social History

Hobbies/Activities:_____

Caffeine intake per day/type:_____ Tobacco use per day/type:_____

Alcohol intake per day/type:_____ Recreation drug use per day/type:_____

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