MEDICAL HISTORY FORM

Date _____ Referring Doctor _____

Name (print) _____ Age_____ Birthdate _____

1. What are you being seen for today? _____
2. When did the accident occur or the symptoms start? _____
3. If it was an injury, where and how did it happen? _____

_____

4. Is this a workers' comp claim? _____
5. Is there any history of this or a similar problem prior to the current condition? _____

_____

6. Who is your primary care physician? _____
7. Which pharmacy do you use? _____
8. Please list any medications you are now taking, prescription and over the counter.

Name of medication	Dosage (example 10 mg)	How often

Allergies (include all drug allergies and describe reaction) _____

_____

9. Do you drink alcohol? ❑ No ❑ Yes How many drinks per week?_____

   Do you smoke or chew tobacco? ❑ No ❑ Yes How many per day? _____ How long? _____
10. Are you ❑ Right handed or ❑ Left handed?
11. Height _____ Weight _____ Occupation _____
12. Do you get regular exercise? ❑ No ❑ Yes (What type and how often?) _____

_____

Please continue on reverse side of this form.

13. List any **fractures** or other **serious injuries** with date and type: _____

_____

_____

14. List **operations** and dates:

_____

_____

_____

_____

15. **Orthopedic History** - Please check any of the following conditions you have had or now have.

❑ Arthritis	❑ Torn cartilage	❑ Sprained joints	❑ Joint pain
❑ Gout	❑ Joint infection	❑ Dislocated joints	❑ Neck or back pain
❑ Osteopenia	❑ Osteoporosis	❑ Bursitis	❑ Tendinitis
❑ Torn muscles or tendons	❑ Problems you were born with	❑ Rheumatoid arthritis	❑ Stiff joints ❑ Use cane / walker

16. **Past Medical History** - Please check any of the following conditions you have had or now have.

❑ High blood pressure	❑ Heart problems	❑ Bleeding problems	❑ Blood clots
❑ Hiatal hernia	❑ Bladder problems	❑ Urinary infections	❑ Kidney problems
❑ Colitis or Crohns	❑ Ulcers	❑ Seizures	❑ Stroke
❑ Emphysema	❑ Diabetes	❑ Pneumonia	❑ Asthma
❑ Thyroid problems	❑ HIV / AIDS	❑ Hepatitis	❑ Staph infections
❑ Skin problems	❑ Gallbladder problems	❑ Psychiatric problems	❑ Cancer ❑ Loss of sensation
❑ Trouble hearing	❑ Corrective eyewear	❑ Trouble swallowing	❑ Depression
❑ Severe headaches	❑ Weakness		❑ Sleep apnea

17. Please describe any of the problems you have checked on the lists above or are not listed. _____

_____

_____

_____

_____

18. **Family History** - immediate family: mother, father, brothers, sisters, grandparents:

❑ Arthritis ❑ Heart problems ❑ Diabetes ❑ Cancer

❑ Other: _____

_____

Thank You

CURRENT REVIEW OF SYSTEMS
(A REVIEW OF PROBLEMS YOU ARE CURRENTLY HAVING)

Patient Name: _____ Date of Birth: _____

CONSTITUTIONAL

	YES	NO
Recent Weight Change		
Chills		
Fever		
Appetite Change		

HEENT

	YES	NO
Change in vision		
Headaches		
Earaches		
Sore Throat		
Hoarseness		

CARDIOVASCULAR

	YES	NO
Chest pain		
Palpitations		
Swelling of feet or hands		
Leg cramping/limping		

RESPIRATORY

	YES	NO
Wheezing		
Shortness of Breath		
Cough		
Chest Congestion		

GASTROINTESTINAL

	YES	NO
Diarrhea		
Bloody stool		
Nausea		
Vomiting		
Constipation		

GENITOURINARY

	YES	NO
Blood in urine		
Burning/painful urination		
Frequent urination		
Incontinence		
Urgency		

MUSCULOSKELETAL

	YES	NO
Weak muscle		
Atrophy		
Joint swelling		
Joint pain		

INTEGUMENTARY (skin)

	YES	NO
Rash or itching		
Ulcers		
Lesions		
Masses		

NEUROLOGIC

	YES	NO
Numbness (feet,hands)		
Weakness		

PSYCHIATRIC

	YES	NO
Memory loss		
Depression		
Anxiety		

ENDOCRINE

	YES	NO
Sensitive to cold		
Sensitive to heat		

HEMATOLOGY/LYMPHATIC

	YES	NO
Anemia		
Easily Bleed		
Easily Bruise		
Enlarged glands		

ALLERGIC/IMMUNOLOGIC

	YES	NO
Rhinitis		
Itching		
Infections		
Latex Allergy		

Food Allergies:

_____

_____

Medication Allergies:

_____

_____

Environmental Allergies:

_____

_____