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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?

Please continue on reverse side of this form.

11. Height _____ Weight _____ Occupation _____

12. Do you get regular exercise? ☐ No ☐ Yes (What type and how often?) _____

_____

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

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

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

HEENT
- ☐ Change in vision
- ☐ Headaches
- ☐ Earaches
- ☐ Sore Throat
- ☐ Hoarseness

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitations
- ☐ Swelling of feet or hands
- ☐ Leg cramping/limping

RESPIRATORY
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Chest Congestion

GASTROINTESTINAL
- ☐ Diarrhea
- ☐ Bloody stool
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation

GENITOURINARY
- ☐ Blood in urine
- ☐ Burning/painful urination
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Urgency

MUSCULOSKELETAL
- ☐ Weak muscle
- ☐ Atrophy
- ☐ Joint swelling
- ☐ Joint pain

INTEGUMENTARY (SKIN)
- ☐ Rash or itching
- ☐ Ulcers
- ☐ Lesions
- ☐ Masses

NEUROLOGIC
- ☐ Numbness (feet, hands)
- ☐ Weakness

PSYCHIATRIC
- ☐ Memory loss
- ☐ Depression
- ☐ Anxiety

ENDOCRINE
- ☐ Sensitive to cold
- ☐ Sensitive to heat

HEMATOLOGY/LYMPHATIC
- ☐ Anemia
- ☐ Easily Bleed
- ☐ Easily Bruise
- ☐ Enlarged glands

ALLERGIC/IMMUNOLOGIC
- ☐ Rhinitis
- ☐ Itching
- ☐ Infections
- ☐ Latex Allergy

Food Allergies:

_____
_____

Medication Allergies:

_____
_____

Environmental Allergies:

_____
_____