



Medical History

The following information is very important to your health, please take time to fully and accurately complete this form.

NAME: Last: _____ First: _____ MI: _____ Date: _____
 DATE OF BIRTH: _____ WEIGHT: _____ HEIGHT: _____ AGE: _____ LEFT HANDED RIGHT HANDED

Referring Physician Information: Name: _____ Address: _____ Phone: _____	Family Physician Information: Name: _____ Address: _____ Phone: _____
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MEDICATIONS (List all current medications - prescription and non-prescription, vitamins and supplements)

Medication	Dose and How Often	Medication	Dose and How Often

ALLERGIES and REACTIONS (List allergies to Medications, Metals or Latex)

Name of Allergy Item	Reaction	Name of Allergy Item	Reaction

HISTORY OF PRESENT PROBLEMS

Describe your problem or reason for your visit. _____

Is your problem the result of an injury? If YES, how did the injury occur? Yes No Date of Injury _____

Where did your injury occur? (work, home, car etc.) _____

EVALUATION OF PAIN / DISCOMFORT

What body part is affected? _____ Left Right

When did the problem start? _____

When does the problem occur? _____ How long does it last? _____

What makes it feel better? _____

What makes it feel worse? _____

PAIN SCALE (Circle one number) NO PAIN 1 2 3 4 5 6 7 8 9 10 SEVERE PAIN
 MILD MODERATE SEVERE

Does pain wake you during sleep? No Yes, Details: _____

PREVIOUS TREATMENT FOR THIS PROBLEM

Diagnostic Testing: X-RAY CT MRI EMG OTHER: _____

Medications: _____

Physical Therapy / Location: _____

Other treatment for this injury: _____	Names of Physicians _____
Have other Physicians seen you for this problem? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Is this condition being covered by Worker's Compensation? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Is there a lawsuit or litigation pending in regard to your injury? <input type="checkbox"/> YES <input type="checkbox"/> NO	

Last Date Worked: _____

Current Work Restrictions: _____ By Whom? _____

PLEASE TURN FORM OVER AND COMPLETE REVERSE SIDE.



PAST SURGICAL HISTORY (PLEASE CIRCLE YES OR NO)

Y N Appendectomy	Y N Gall Bladder Removal	Y N Hernia	Y N Other _____
Y N Abdominal	Y N Colostomy	Y N Hysterectomy	_____
Y N Bladder	Y N Colon Resection	Y N Mastectomy	
Y N Breast Biopsy	Y N Heart	Y N Prostate	
Y N Cataract	Y N Hemorrhoids	Y N Tonsillectomy	

ORTHOPEDIC HISTORY

Y N Arthroscopy of What? _____	Y N Fractures of What? _____
Y N Joint Replacement Where? _____	Y N Back/Neck Surgery - When? _____

PAST MEDICAL HISTORY / CURRENT DIAGNOSES (PLEASE CIRCLE YES OR NO)

Y N Diabetes	Y N Pregnancy (Current or recent) Date: _____	Y N Hepatitis	Y N Bleeding Disorder
Y N High Blood Pressure	Y N Multiple Sclerosis	Y N Stomach Ulcers	Y N Rheumatoid Arthritis
Y N Thyroid (Hypo or Hyper)	Y N Heart Disease	Y N Gastrointestinal Disease	Y N Osteoarthritis
Y N Parathyroid	Y N Heart Attack	Y N Liver Disease	Y N Gout
Y N Tuberculosis	Y N Irregular Heart Beat	Y N Prostate	Y N Cancer
Y N Stroke	Y N Asthma	Y N Kidney Disease	Y N Glaucoma
Y N Seizure Disorder	Y N Bronchitis	Y N Vascular Disease (Circulation Problems)	Y N Other (Describe):
Y N AIDS/HIV	Y N Blood Clots in legs or lungs	Y N Bladder Disease	
Y N Parkinson's Disease		Y N Skin Disorder	

FAMILY HISTORY (PLEASE CIRCLE YES OR NO)

Y N Blood Clots in legs or lungs	Y N Cancer	Y N Diabetes
Y N Bleeding Disorder	Y N Muscle or Bone Disease	Y N Malignant Hyperthermia
Y N Osteoarthritis	Y N Heart Disease	Y N Other (Describe):

SOCIAL HISTORY

<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated
<input type="checkbox"/> Single	<input type="checkbox"/> Widow / Widower	

RESIDENCE

<input type="checkbox"/> Alone	<input type="checkbox"/> With Friends	<input type="checkbox"/> Nursing Home/Retirement Home	<input type="checkbox"/> Other (Describe):
<input type="checkbox"/> With Spouse	<input type="checkbox"/> With Family	Name of facility:	

USER OF

Y N Tobacco Pks/Day _____ # of years _____ Year quit _____	Y N Alcohol
<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chew <input type="checkbox"/> Other: _____	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Weekly <input type="checkbox"/> Daily

CURRENT SYMPTOMS (PLEASE CIRCLE YES OR NO)

Y N Weight loss or gain	Y N Generalized muscle weakness	Y N Irregular heart beat	Y N Urgency of urine
Y N Fatigue	Y N Deformity	Y N Swelling of ankles	Y N Retention of urine
Y N Fever	Y N Frequent or unusual headaches	Y N Blood clots in legs or lungs	Y N Paralysis
Y N Chills	Y N Hearing loss	Y N Varicose veins	Y N Loss of sensation
Y N Night Sweats	Y N Mouth or dental infections	Y N Bleeding problems	Y N Depression
Y N Rashes	Y N Loss of Vision	Y N Nausea	Y N Episodes of mania
Y N Open wound or sores	Y N Shortness of breath	Y N Vomiting	Y N Inability to sleep
Y N Drainage	Y N Difficulty Breathing	Y N Diarrhea - Chronic	
Y N Multiple joint pain	Y N Productive cough	Y N Incontinence	
Y N Multiple joint swelling	Y N Chest pain or pressure	Y N Frequency of urine	

Patient Signature**Date**

By signing this form I attest that the above information is true and correct to the best of my belief.

HISTORY REVIEWED BY - OFFICE USE ONLY -

Name:	Date:
Name:	Date:
Name:	Date:
Name:	Date:

THANK YOU