

Medical History Form

Today's Date: _____

Name: _____
First MI Last

Height: _____ Weight: _____ Heart Rate: _____

Hand Dominance: Left Right Both

What is your pain on a scale of 0-10 (10 being the worst) ___/10 Activity ___/10 Rest

Chief Complaint:

Problem that brings you to our facility: _____

Previous treatment for this problem: _____

List the Body Part (Example: Knee, Wrist): _____ Left-side Right-side

Date of Injury/Onset: _____ Is this a Workman's Compensation injury? Yes No
MM/DD/YYYY

General Medical History:

Neurological

Stroke	YES	NO
Migraine	YES	NO
Concussion	YES	NO
Peripheral Neuropathy	YES	NO
Epilepsy	YES	NO

Cardiovascular

Heart Attack	YES	NO
High Blood Pressure	YES	NO
Coronary Artery Disease	YES	NO
Elevated Cholesterol	YES	NO

Kidney

Renal Insufficiency	YES	NO
Kidney Stones	YES	NO

Gastrointestinal

Ulcers	YES	NO
Reflux	YES	NO

Skin

Psoriasis	YES	NO
Eczema	YES	NO

Endocrine

Diabetes	YES	NO
Thyroid Disease	YES	NO
Prednisone Use	YES	NO

Pulmonary

Asthma	YES	NO
Emphysema	YES	NO
COPD	YES	NO
Pulmonary Embolism	YES	NO

Infectious

HIV/AIDS	YES	NO
Hepatitis B	YES	NO
Hepatitis C	YES	NO
TB	YES	NO
Recent Tick Bite	YES	NO

Cancer

Type:	YES	NO

Musculoskeletal

Osteoarthritis	YES	NO
Rheumatoid Arthritis	YES	NO
Fibromyalgia	YES	NO
Osteoporosis	YES	NO
Gout	YES	NO

Hematological

Bleeding Problems	YES	NO
Blood Clots	YES	NO
Anemia	YES	NO
Blood Transfusion	YES	NO

Psychological

Depression	YES	NO
Anxiety	YES	NO
ADHD	YES	NO
Bipolar	YES	NO
Claustrophobia	YES	NO

Problem Not Listed

Explain:	YES	NO

Medical History Form

Previous Surgery/Hospitalizations:

No history of surgery.

<i>List surgery/Reason for hospitalization:</i>	<i>Hospital/Facility:</i>	<i>Date:</i>
1. _____	a. _____	b. _____
2. _____	a. _____	b. _____
3. _____	a. _____	b. _____
4. _____	a. _____	b. _____
5. _____	a. _____	b. _____
6. _____	a. _____	b. _____

Have you ever had General Anesthesia? YES NO

Have you ever had any problems with anesthesia? YES NO

If YES, please explain: _____

Current Medications: (List any prescription, drugs, and/or non-prescription medications, including vitamins, nutritional supplements, or anything taken orally.)

I do not take any medications.

<i>List names of medications:</i>	<i>Dose or strength:</i>	<i>Reason for medication:</i>
1. _____	a. _____	b. _____
2. _____	a. _____	b. _____
3. _____	a. _____	b. _____
4. _____	a. _____	b. _____
5. _____	a. _____	b. _____
6. _____	a. _____	b. _____
7. _____	a. _____	b. _____
8. _____	a. _____	b. _____
9. _____	a. _____	b. _____
10. _____	a. _____	b. _____

Allergies:

I have NO Allergies to Medications.

<i>List medications or Allergens:</i>	<i>Describe reaction:</i>
1. _____	a. _____
2. _____	a. _____
3. _____	a. _____
4. _____	a. _____

Are you allergic to Latex? YES NO

Medical History Form

Family History: Do your parents or siblings have any of the following problems?

I do not know my family medical history.

Diabetes	YES	NO
Heart Disease	YES	NO
Bleeding Problems	YES	NO
Lung Disease	YES	NO

Blood Clots	YES	NO
Stroke	YES	NO
Cancer	YES	NO

Social History:

Marital Status: Single Married Other: _____

Do you live alone: YES NO If not with whom? _____

Work Status: Employed Unemployed Disabled Student Retired

Do you use tobacco products? Never YES How many packs/day? _____

Quit-Smoked _____ packs/day for _____ years

Do you drink alcohol? Never Daily 1-2x/week 1-2x/month 1-2x/year

Do you currently use or have a history of illicit substance use? YES NO

Review of Systems: Are you experiencing any of the following:

Neurological

Seizures	YES	NO
Migraine	YES	NO
Balance Problems	YES	NO
Fainting	YES	NO

Cardiovascular

Chest Pain	YES	NO
Abnormal Heartbeat	YES	NO
Poor Heart Function	YES	NO

Psychiatric

Depression	YES	NO
Stress	YES	NO

Musculoskeletal

Joint Swelling or Pain	YES	NO
Muscle Aches	YES	NO

Skin

Frequent Rashes	YES	NO
Frequent Itching	YES	NO
Easy Bruising	YES	NO

Lung

Cough	YES	NO
Shortness of Breath	YES	NO
Sleep Apnea	YES	NO

General

Unexplained Weight Loss	YES	NO
Fevers, Chills, Sweats	YES	NO
Marked Fatigue	YES	NO
Difficulty Sleeping	YES	NO

Gastrointestinal

Nausea/Vomiting	YES	NO
Heartburn or Ulcers	YES	NO
Constipation	YES	NO
Blood in Stool	YES	NO
Stomach Pain	YES	NO

Hematological

Bleeding Problems	YES	NO
Blood Clots	YES	NO

Eye, Ear, Nose Throat

Difficulty Swallowing	YES	NO
Hoarseness	YES	NO
Nasal Congestion	YES	NO
Hearing Loss	YES	NO
Vision Loss	YES	NO

Genital-Urinary

Burning with Urination	YES	NO
Urinary Incontinence	YES	NO
Urinary Frequency	YES	NO
Pelvic Pain	YES	NO

X _____
Patient Signature Date

X _____
Physician's Signature Date