

MEDICAL HISTORY

Patient's Name: _____ Age _____ D.O.B. _____ - _____ - _____

Sex: _____ Height: _____ Weight: _____ Language: _____ Race: _____

Who referred you to us? Doctor, Attorney, Friend, Family Member, etc. _____

Hand dominance: Right or Left (CIRCLE ONE) DATE OF INJURY: _____ Is this a work related injury? YES NO

Employer: _____ Occupation: _____ Last date worked: _____

If Student Present School? _____ Is this a sports injury? YES NO

CURRENT SYMPTOMS: _____

WHERE AND HOW DID YOU INJURE YOURSELF? _____

DID YOU SEE ANOTHER DOCTOR FOR THIS PROBLEM? YES NO IF SO, WHO? _____
WHAT DID THIS PHYSICIAN DO FOR YOU? _____

DID YOU HAVE ANY X-RAYS OR ANY OTHER TESTING PERFORMED SUCH AS AN MRI? YES NO
IF SO, PLEASE LIST WHAT WERE PERFORMED AND WHERE? _____

HAVE YOU EVER BEEN ON WORKERS COMP BEFORE? YES NO If so, WHEN and WHAT FOR? _____

HAVE YOU EVER FILED A SUIT FOR THIS INJURY OR ANY INJURY IN THE PAST? (Please Explain) _____

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING: (Please check if any apply.)

	YOU	FAMILY	PLEASE EXPLAIN AND GIVE FAMILY MEMBER RELATION
ALCOHOLISM	_____	_____	_____
ANEMIA	_____	_____	_____
BLEEDING DISORDER	_____	_____	_____
CANCER	_____	_____	_____
DENTAL PROBLEMS	_____	_____	_____
DIABETES	_____	_____	_____
GOUT	_____	_____	_____
HEART TROUBLE	_____	_____	_____
HIGH BLOOD PRESSURE	_____	_____	_____
KIDNEY TROUBLE	_____	_____	_____
LIVER DISEASE	_____	_____	_____
LUNG DISEASE	_____	_____	_____
MENTAL ILLNESS	_____	_____	_____
OSTEOARTHRITIS	_____	_____	_____
PHLEBITIS	_____	_____	_____
RHEUMATOID ARTHRITIS	_____	_____	_____
SEIZURES	_____	_____	_____
STROKE	_____	_____	_____
THYROID PROBLEMS	_____	_____	_____
TUBERCULOSIS	_____	_____	_____
ULCERS	_____	_____	_____
UNEXPLAINED WEIGHT LOSS	_____	_____	_____
OTHER MAJOR MEDICAL ILLNESS	_____	_____	_____

LIST ALL SURGICAL PROCEDURES

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

LIST ALL HOSPITALIZATIONS

Reason for Hospital Stay	Date
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATIONS OR SUBSTANCES? YES _____ NO _____

Please list the medication(s) you are allergic to:

What type of allergic reaction do you have?

(OVER PLEASE)

Date Completed: _____

