# 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:** _____

**PATIENT'S NAME:** _____

**LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (If more room is needed please ask receptionist for another sheet)**

| Name and Strength | Dosage (# of Tablets) | # Times per Day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**NAME OF YOUR PHARMACY:** _____

**LOCATION OF YOUR PHARMACY:** _____

**DO YOU HAVE A PHYSICAL THERAPIST?** YES NO IF YES, SUPPLY NAME: _____

**REVIEW OF SYSTEMS:**

HAVE YOU **RECENTLY** HAD OR DO YOU NOW HAVE: (Please check yes if any of the following apply:)

| YES | | YES | | YES | |
|---|---|---|---|---|---|
| ____ | Abnormal heart beat | ____ | Frequent headaches | ____ | Nose bleeds |
| ____ | Badly swollen ankles | ____ | Frequent loose bowels | ____ | Poor appetite |
| ____ | Blackouts | ____ | Frequent rash | ____ | Reading glasses |
| ____ | Blood in bowel movements | ____ | Frequent urination | ____ | Recent weight change |
| ____ | Burning on urination | ____ | Get up every night to urinate | ____ | Seizures |
| ____ | Calf cramp with walking | ____ | Gum trouble | ____ | Shortness of breath |
| ____ | Change of vision | ____ | Heart or chest pains | ____ | Stomach pain |
| ____ | Chills or Fever | ____ | Hemorrhoids | ____ | Toothache |
| ____ | Depression | ____ | Hoarseness | ____ | Trouble sleeping |
| ____ | Difficulty starting urination | ____ | Hot or cold spells | ____ | Ulcers |
| ____ | Difficulty stopping urination | ____ | Loss of hearing | **WOMEN ONLY:** | |
| ____ | Difficulty swallowing | ____ | Morning cough | ____ | Frequent Spotting |
| ____ | Ear pain | ____ | Nausea or vomiting | ____ | Irregular Periods |
| ____ | Frequent belching | ____ | Nervous exhaustion | ____ | Vaginal Discharge |
| ____ | Frequent constipation | ____ | Nervous tension | | |

**SOCIAL HISTORY:**

Alcohol Use: Never _____ Occasional _____ Moderate _____ Heavy _____

Blood Transfusion: YES _____ NO _____ If yes, please give date: _____

Number of Children: _____Presently Living Alone: YES _____NO _____If no, who lives with you? _____

Have you ever been tested for HIV or AIDS? (optional) YES _____ NO _____

Do you consider yourself at risk for HIV or AIDS?(optional) YES _____ NO _____

Hobbies and Special Interests: _____

Marital Status: Never Married _____ Married _____ Divorced _____ Widowed _____

Smoking History: _____Current everyday smoker ____Current someday smoker _____Former smoker

Number of packs per day _____ Number of years _____ ____ Never smoked

Have you had a flu vaccine this year? Yes_____ When?_____ No_____

Have you had a pneumonia vaccine? Yes_____When?_____ No_____