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_____

List the medication(s) you are allergic to:	What type of allergic reaction do you have?	Severity of Reaction (Circle one for each allergy)
		Severe, Mild, Moderate, Life threatening
		Severe, Mild, Moderate, Life threatening
		Severe, Mild, Moderate, Life threatening
		Severe, Mild, Moderate, Life threatening
		Severe, Mild, Moderate, Life threatening

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_____