

MEDICAL HISTORY FORM

Date _____

Referring Doctor _____

Name (print) _____ Age _____ Birthdate _____

1. What are you being seen for today? _____
2. When did the accident occur or the symptoms start? _____
3. If it was an injury, where and how did it happen? _____

4. Is this a workers' comp claim? _____
5. Is there any history of this or a similar problem prior to the current condition? _____

6. Who is your primary care physician? _____
7. Which pharmacy do you use? _____
8. Please list any medications you are now taking, prescription and over the counter.

Name of medication	Dosage (example 10 mg)	How often

Allergies (include all drug allergies and describe reaction) _____

9. Do you drink alcohol? No Yes How many drinks per week? _____
Do you smoke or chew tobacco? No Yes How many per day? _____ How long? _____
10. Are you Right handed or Left handed?
11. Height _____ Weight _____ Occupation _____
12. Do you get regular exercise? No Yes (What type and how often?) _____

Please continue on reverse side of this form.

13. List any fractures or other serious injuries with date and type: _____

14. List operations and dates: _____

15. **Orthopedic History** - Please check any of the following conditions you have had or now have.

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Torn cartilage | <input type="checkbox"/> Sprained joints | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Joint infection | <input type="checkbox"/> Dislocated joints | <input type="checkbox"/> Neck or back pain |
| <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Tendinitis |
| <input type="checkbox"/> Torn muscles or tendons | <input type="checkbox"/> Problems you were born with | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Stiff joints |
| | | | <input type="checkbox"/> Use cane / walker |

16. **Past Medical History** - Please check any of the following conditions you have had or now have.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Urinary infections | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Colitis or Crohns | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Staph infections |
| <input type="checkbox"/> Skin problems | <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Trouble hearing | <input type="checkbox"/> Corrective eyewear | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Loss of sensation |
| <input type="checkbox"/> Severe headaches | <input type="checkbox"/> Weakness | | <input type="checkbox"/> Depression |
| | | | <input type="checkbox"/> Sleep apnea |

17. Please describe any of the problems you have checked on the lists above or are not listed. _____

18. **Family History** - immediate family: mother, father, brothers, sisters, grandparents:

- | | | | |
|------------------------------------|---|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Other: | _____ | | |

Thank You