

PATIENT MEDICAL HISTORY



Patient Name _____ Male Female DOB _____ Age _____ Height _____ Weight _____
last first middle initial mm/dd/yyyy

Occupation _____ Retired?

Marital Status: Single Married
 Separated Divorced
 Widower Dependent
 Domestic Partner

Primary Care Physician _____

Referred by _____

Is this a work related injury? No Yes

Race: White/Caucasian Asian
 Black/African American Native Hawaiian/Other Pacific Islander
 American Indian or Alaska Native Other _____
 Prefer Not to Disclose Unknown

Ethnicity: Hispanic or Latino Prefer Not to Disclose
 Not Hispanic or Latino Unknown

Personal Medical History: (Please check if YOU currently have or had the following diseases/conditions and circle any that apply.)

- | | |
|--|---|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Epilepsy/Seizures/Convulsions | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer (Type: _____) |
| <input type="checkbox"/> Heart Problems/Heart Attack/Irregular Heartbeat | <input type="checkbox"/> Communicable Diseases |
| <input type="checkbox"/> DVT/Pulmonary Embolism/Blood Clots | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia/Bleeding Disorder | <input type="checkbox"/> Antibiotic Resistant Infection/MRSA |
| <input type="checkbox"/> Asthma/COPD/Emphysema/Breathing Problems | <input type="checkbox"/> Allergy to Antibiotics (Reaction: _____) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Steroid Use |
| <input type="checkbox"/> Liver Diseases/Hepatitis (Type: _____) | <input type="checkbox"/> Metal Allergy |
| <input type="checkbox"/> Kidney Disease/Kidney Stones | <input type="checkbox"/> Anesthesia Difficulties/Malignant Hyperthermia |
| <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Other (List: _____) |
| | <input type="checkbox"/> None |

Previous Surgeries: (Please list ALL previous surgeries and the date.)

Procedure / Date	Procedure / Date
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Medications: (Please list ALL medications including prescriptions, over-the-counter medications and blood thinning medications such as Coumadin, Plavix, Aspirin, etc.)

Medication	Dose	How Often
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Patient Name _____
last first

Allergies: (Please list **ALL** allergies including contrast dyes, metal, latex or other.)

Name	Specify Reaction (hives, rash, breathing difficulty, anaphylaxis)
1.	
2.	
3.	
4.	
5.	

Family Medical History: (Please check if anyone in your **FAMILY** has or had the following diseases/conditions and circle the applicable condition.)

- | | |
|---|---|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Diseases/Hepatitis (Type: _____) |
| <input type="checkbox"/> Epilepsy/Seizures/Convulsions | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Problems/Heart Attack/Irregular Heartbeat/Stroke | <input type="checkbox"/> Gout |
| <input type="checkbox"/> DVT/Pulmonary Embolism/Blood Clots | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Anemia/Bleeding Disorder | <input type="checkbox"/> Cancer (Type: _____) |
| <input type="checkbox"/> Asthma/Breathing Problems/Emphysema | <input type="checkbox"/> Metal Allergy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other (_____) |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> None |

Social History:

- Do you use tobacco? No Yes Packs Per Day: _____ If Quit when: _____
- Do you drink alcohol? No Yes How Much/Often: _____
- Are you pregnant? No Yes Possibly
- Current or history of drug use? No Yes Type: _____
- How many children do you have? _____ Number living with you? _____

Review of Systems: (Please check if **YOU** are experiencing any of the following symptoms and circle any that apply.)

- Fever/Weight Loss or Gain/Chills/Fatigue
- Sore Throat/Difficulty Swallowing/Nose Bleeds/Ear or Hearing Problems/Headache/Migraines
- Excessive Thirst or Appetite/Excessive Urination/Heat or Cold Intolerable
- Visual Difficulty/Redness/Watery Eyes
- Chest Pain/Palpitations/Fainting/Murmurs
- Cough/Sputum Production/Snoring/Short of Breath/Wheezing
- Blood in Stool/Loss of Bowel Control/Nausea/Vomiting/Ulcers
- Bladder/Urological Problems/Painful Urination/Prostate Problems
- Bleeding Problems/Easy Bruising
- Joint Swelling/Stiffness/Redness/Heat/Muscle Pain/Swelling
- Depression/Nervousness/Anxiety/Hallucinations
- Skin Disorders/Rash/Poor Healing/Redness

The above information is true and correct to the best of my knowledge.

Patient Signature _____

Date _____

M.D. Review _____

Date _____