Patient Medical History

Name: ______________________ Date: ____________ Chart #: ______________________

Age: ________ Date of Birth: ____________ Height: ______________ Weight: ______________________

OCCUPATION (If retired, please list your occupation prior to retirement): ______________________

PRIMARY CARE PROVIDER (First *and* Last name!): ______________________

Is your primary care provider a ( ) Doctor ( ) Physician Assistant/PA ( ) Nurse Practitioner

Chief Complaint/why are you seeing the doctor today: ______________________

Have you ever been treated for this problem before? ❑ Yes ❑ No

Date of injury/onset of problem: ______________________

The current problem is the result of (*Check all that apply*): ❑ Car Accident ❑ Work Accident ❑ Other ______________

MEDICAL HISTORY – *Are you currently receiving treatment or have you received treatment in the past for any of the following conditions?*

Yes	No	Yes	No	Yes	No	Yes	No
☐	☐Anemia	☐	☐Epilepsy	☐	☐Kidney Problems	☐	☐Pulmonary Embolism
☐	☐Arthritis	☐	☐Gallbladder Problems	☐	☐Liver Disease	☐	☐Rheumatic Fever
☐	☐Asthma	☐	☐Gout	☐	☐Lung Problems	☐	☐Sexually Transmitted Disease
☐	☐Birth Defects	☐	☐Heart Disease	☐	☐Phlebitis		
☐	☐Bladder Problems	☐	☐Hepatitis	☐	☐MRSA/Staph Infection	☐	☐Stroke/TIA
☐	☐Bleeding/Bruising	☐	☐HIV/AIDS	☐	☐Osteoporosis	☐	☐Tuberculosis
☐	☐Cancer-Type __________	☐	☐High Cholesterol	☐	☐Peripheral Vascular Disease	☐	☐Thyroid Issues
☐	☐DVT/Blood Clots	☐	☐Hypertension	☐	☐Polio	☐	☐Ulcer-Type: __________
☐	☐Diabetes: Type ________ Complications ________	☐	☐Intestinal/Bowel Issues	☐	☐Psychological Issues		

Are there any other medical problems we should know about? ______________________

____

Are you right- or left hand dominant? ☐ Right ☐ Left Are you or could you be pregnant? ☐ Yes ☐ No

Do you exercise or participate in sports regularly? ☐ Yes ☐ No Type and Frequency: ______________________

Medications – *Please list all medications you take that are by prescription or over-the-counter (use extra paper if needed)*

Medication Name	Dosage/# of times per day taken	Reason for taking

Allergies – *Please describe any current or past allergic reactions*

☐ **I DO NOT HAVE ANY ALLERGIES.**

Drug allergic to:	Reaction (itching, cough, hives, etc.)	How was/is the reaction treated?

SURGERIES AND HOSPITALIZATIONS – PLEASE BE SURE TO FILL OUT YEAR, SURGEON'S NAME AND IF YOU HAD COMPLICATIONS

☐ **I HAVE NOT HAD any surgeries or hospitalizations**

Arthroscopy ______________ Year ________ Physician ______________ Complications? ______

Joint Replacement______________ Year ________ Physician ______________ Complications? ______

Bone or Joint Reconstruction______________ Year ________ Physician ______________ Complications? ______

Spine Surgery ______________ Year ________ Physician ______________ Complications? ______

Other General Surgery______________ Year ________ Physician ______________ Complications? ______

Other Hospitalization______________ Year ________ Physician ______________ Complications? ______

CONTINUED ON NEXT PAGE!!

Name: ______________________________ **Date:** ________________________ **Page 2 of Medical History**

FAMILY HISTORY: If any relatives have had any of the following conditions, please noted by using **M**-mother, **F**-father, **GP**-grandparent(s), **S**-Sibling, **O**-Other and, **if applicable**, their age at their death.

Alzheimer's	________	Diabetes	________	Osteoporosis	________	Other:
Arthritis	________	Gout	________	Stroke	________	____________________
Cancer/Type	________	Heart Disease	________	Sudden Death	________	____________________
						____________________

SOCIAL HISTORY:

Do you smoke or chew tobacco or use smokeless tobacco? ☐ Yes ☐ No Number: ______________ Packs per day for _______ Years

Do you drink alcoholic beverages? ☐ Yes ☐ No Amount and frequency: ______________________________

Do you use recreational drugs? ☐ Yes ☐ No Type and frequency: ______________________________

REVIEW OF SYSTEMS-*Please check any symptoms that you experience regularly –IF YOU HAVE HAD NONE, PLEASE CHECK THE **NONE** BOX.*

General
- ☐ Fever
- ☐ Weight change
- ☐ Hormonal problems
- ☐ Other ______________
- ☐ **NONE**

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ Fluid/swelling in extremities
- ☐ Other______________
- ☐ **NONE**

Kidney/Bladder
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Other______________
- ☐ **NONE**

Eyes
- ☐ Glasses/contacts
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other______________
- ☐ **NONE**

Respiratory
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Wheezing
- ☐ Other______________
- ☐ **NONE**

Ear/Nose/Throat
- ☐ Difficulty swallowing
- ☐ Ear pain
- ☐ Seasonal allergies
- ☐ Other______________
- ☐ **NONE**

Gastrointestinal
- ☐ Heartburn
- ☐ Diarrhea/constipation
- ☐ Abdominal pain
- ☐ Other______________
- ☐ **NONE**

Skin
- ☐ Rashes
- ☐ Lumps
- ☐ Other______________
- ☐ **NONE**

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Blood problems
- ☐ Clotting disorder
- ☐ Lymph problems
- ☐ Other______________
- ☐ **NONE**

Neurological
- ☐ Headaches
- ☐ Numbness
- ☐ Tingling
- ☐ Seizures
- ☐ Weakness
- ☐ Other______________
- ☐ **NONE**

Psychological
- ☐ Anxiety
- ☐ Depression
- ☐ Mood swings
- ☐ Other______________
- ☐ **NONE**

Pain Scale – if you are having pain, please rate the intensity of your pain on a scale of 1-10

No Pain 0	1	2	3	4	5	6	7	8	9	Extreme Pain 10

Patient Name: ______________________________ Date: ______________

Patient Signature: ______________________________ Date: ______________