Account # _____ **Patient Medical History Form** Date _____

Patient: (First)_____ (M.I.)_____ (Last)_____
Birthdate: _____ Age:_____ Are you: ☐ Left-handed ☐ Right-handed
Patient's Employer:_____
Job Title: _____ How long employed: _____

Name of Physician/Hospital that referred you:_____
Family Physician:_____
Have you seen your family physician in the past year? _____
Preferred Pharmacy: _____

History of Present Illness

Reason for Today's Visit: _____ ☐ Left ☐ Right
Date of Injury/Condition: _____
Workmen's Comp Injury? Yes No Other type of accident injury? Yes No
Auto Accident Injury? Yes No Please explain: _____
How severe is your pain on a scale of 1-10 with 10 being the worst pain ever felt? _____

Medical History

At any time have you had problems with any of the following?

- ☐ Diabetes
- ☐ Stroke
- ☐ Seizures
- ☐ Glaucoma
- ☐ Ears/Nose/Throat/Mouth Problems
- ☐ Thyroid Trouble
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Arrhythmia: _____
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Breast Disease/Cancer
- ☐ Stomach Ulcers
- ☐ Liver Disease/Hepatitis
- ☐ Anemia
- ☐ Bowel/Intestinal Problems
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Hiatel Hernia
- ☐ Reflux
- ☐ Prostate Disease (males)
- ☐ MRSA
- ☐ Cancer
  Type _____
- ☐ Arthritis
- ☐ HIV/AIDS
- ☐ Psoriasis
- ☐ Scleroderma
- ☐ Mental Health Disorder
- ☐ Treatment of Drug and/or Alcohol Abuse
- ☐ Bleeding Disorders
- ☐ DVT
- ☐ Pulmonary Embolism
- ☐ Lyme Disease
- ☐ Fibromyalgia
- ☐ Sleep Apnea
- ☐ Gout
- ☐ Other
  _____

List any drug allergies or problems taking medication	**Problem (nature of allergic reaction)**
_____	_____
_____	_____
_____	_____

☐ No Known Drug Allergies

List current medications (include vitamins, birth control, etc.)	**Dosage**	**How often?**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ No current medications

List previous surgeries or pregnancies: **Year:**

_____ _____

_____ _____

_____ _____

☐ No Previous Surgeries

Social History

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

How many children? _____

Work Status: ☐ Employed ☐ Homemaker ☐ Retired ☐ Unemployed ☐ Disabled ☐ Student

Describe occupation: _____

Current smoker: ☐ No ☐ Yes How many packs per day? ____ How many years? ____

Former smoker: ☐ No ☐ Yes How many packs per day? ____ How many years? ____

Never Smoked: ☐ (Please Check)

Alcohol use: ☐ Never or rarely ☐ Once a day ☐ Once a week ☐ Once a year

Hobbies or interests: _____

Family History

Have any of your blood relatives had any of the following disorders (please list relationship):

☐ High blood pressure _____
☐ Neck and/or back problems _____
☐ DVT _____
☐ Heart Disease _____
☐ Diabetes _____
☐ Cancer _____
☐ Anesthesia Problems _____
☐ Other _____

Review of Systems

In the past six months, have you had any of the following problems (please list when):

General:
☐ Blackouts _____
☐ Fatigue _____
☐ Repeated fevers _____
☐ Trouble Sleeping _____
☐ Weight Gain _____
☐ Weight Loss _____

Skin:
☐ Skin Rash _____

HEENT:
☐ Frequent Headaches _____
☐ Hearing Difficulty _____
☐ Migraines _____
☐ Sinus/Allergy _____
☐ Vision Problems _____

Cardiovascular:
☐ Chest Pain _____
☐ Irregular Heartbeat _____
☐ Palpitations _____
☐ Shortness of Breath _____

Gastrointestinal:
☐ Diarrhea _____
☐ Heartburn _____

Genitourinary:
☐ Blood in Urine _____
☐ Bladder Control Problems _____
☐ Painful Frequent Urination _____
☐ Testicular Swelling/Pain _____
☐ Vaginal Bleeding/Pain _____

Musculoskeletal:
☐ Back/Neck Pain _____
☐ Joint Pain _____

Neurological:
☐ Numbness _____
☐ Tingling _____

Psychiatric:
☐ Anxiety _____
☐ Depression _____

☐ Other _____

FOR OFFICE USE ONLY: Height _____ Weight _____

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