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 _____