MEDICAL HISTORY

Date _____ Please fill out as accurately as possible as it will assist in your care.

Patient's Name _____ Age _____ Height _____ Weight _____

Why are you seeing the doctor today: (Chief Complaint) _____

How long have you had this problem: _____

Current problem a result of a (n): Check all that apply ☐ Work Accident ☐ Auto Accident ☐ Other Accident

This injury occurred during: ☐ Reaching ☐ Squatting ☐ Kneeling ☐ Hit by an object ☐ Unknown cause

Who referred you to this office: *(Specify Physician, hospital or friend)* _____

Have you had X-rays, MRI, or a CT scan for this problem? If so, when & where? _____

Women: Are you or do you think you may be pregnant? _____

Do you have or have you had any of the following medical conditions?

☐ High blood pressure	☐ Heart attack	☐ Liver disease	☐ Cancer-Type _____
☐ Heart ailment	☐ Chest pain	☐ Kidney disease	☐ Anemia
☐ Heart murmur	☐ Shortness of breath	☐ Bladder problems	☐ Hearing problems
☐ **Pacemaker**	☐ Emphysema	☐ Stomach ulcers	☐ Speech problems
☐ Artificial heart valve	☐ Asthma	☐ Bowel problems	☐ Glaucoma
☐ Heart bypass surgery	☐ Tuberculosis	☐ Balance problems	☐ Cataracts
☐ Angioplasty	☐ Persistent sore throat	☐ Parkinson's disease	☐ Tumors of any kind
☐ Rheumatic fever	☐ Venereal disease	☐ Epilepsy/Seizures	☐ Psychological problems
☐ Scarlet fever	☐ Herpes	☐ Stroke/TIA	☐ Fainting Spells
☐ Diabetes	☐ Hepatitis	☐ Hormone problems	☐ Bleeding disorder
☐ AIDS/HIV	☐ Jaundice	☐ Thyroid problems	☐ Other (*list*)

LIST ALL PREVIOUS SURGERIES _____

_____

Are you allergic to, or have you ever reacted adversely to: *(Check all that apply)*

☐ Local Anesthetic or Novocain ☐ Codeine ☐ Others*(Please list)*

☐ Penicillin ☐ Aspirin _____

☐ Sulfa Drugs ☐ Metals

List all of your current medications: _____

_____

_____

SOCIAL HISTORY

Employment (Occupation) _____ ☐ Retired ☐ Student

Do you live alone? ☐ No ☐ Yes Do you have children? ☐ No ☐ Yes, Number _____

Exercise? ☐ Daily ☐ Weekly ☐ Rarely ☐ Never Type of exercise: _____

Are you on a special diet? ☐ No ☐ Yes Describe: _____

Do you currently smoke: ☐ No ☐ Yes Packs per day _____ Number of years____ Quit smoking? ☐ Yes

Alcohol History: ☐ Never ☐ 1-2 per Year ☐ 1-2 per Month ☐ 1-2 per Week ☐ Daily

History of Substance Abuse? ☐ No ☐ Yes Explain: _____

Family History of Medical or Mental Problems _____