## PATIENT MEDICAL HISTORY

Name: ____________________________________________________ Date of Birth: ____________________

Date: ______________________________________________________ Account #: ______________________

Referring Physician (name, address and phone number):

___

Primary Care Physician (name, address and phone number):

___

Body Part to be seen: Right or Left ___________________________________________________________

Date Injury/ Pain occurred: ____________________ Injury Related: ____No ____ Yes Work Related: ____No ____ Yes

Date first seen for this Injury/Pain: ______________________________________________________________________

List Activities that make it worse: _______________________________________________________________________

Patient Ethnicity: ____________ Patient Race: ___________ Patient Language: ___________ Declined: ______________

Pharmacy of Choice and location: ______________________________________ Phone Number: ____________________

### PAST MEDICAL HISTORY

Do any of these Medical Problems below apply to you? Please check box to the left of those that apply.

- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Atrial Fibrillation
- ☐ Asthma
- ☐ Bleeding Tendency
- ☐ Blood Clots Where?:_______
- ☐ Cardiac Catheterization
- ☐ Chronic Leg Swelling
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irregular or Fast Heartbeat
- ☐ MRSA
- ☐ Pacemaker Placement
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Sleep Apnea CPAP?:______
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Other: LIST BELOW
- ☐ None of the above
- ☐

☐ Cancer: Type: __________________________________________ Treatment: __________________________________________

Cancer Disease State: Active:______________________________ Cancer in Remission: ____________________________

**If checked any of the above, please describe and give date of each:** ________________________________

___

### PAST SURGICAL HISTORY

Please check or list **ALL** of your previous surgeries and indicate the year

- ☐ **NO SURGERIES**
- ☐ Appendectomy Year:_______ Surgeon:__________
- ☐ Bypass/Open Heart Year:_______ Surgeon:__________
- ☐ Cataract Extraction Year:_______ Surgeon:__________
- ☐ Cesarean Delivery Year:_______ Surgeon:__________
- ☐ Gall Bladder Year:_______ Surgeon:__________
- ☐ Hernia Repair Year:_______ Surgeon:__________
- ☐ Hysterectomy Year:_______ Surgeon:__________
- ☐ Tonsillectomy Year:_______ Surgeon:__________
- ☐ Knee surgery Year:_______ Surgeon:__________ Type of Surgery:________________ ____Left ____Right
- ☐ Shoulder surgery Year:_______ Surgeon:__________ Type of Surgery:________________ ____Left ____Right
- ☐ Hip surgery Year:_______ Surgeon:__________ Type of Surgery:________________ ____Left ____Right
- ☐ Neck/Back surgery Year:_______ Surgeon:__________ Type of Surgery:________________ ____Left ____Right
- ☐ Other: List below

| Date | Type of Surgery/Body Part | Surgeon |
| --- | --- | --- |
| | | |
| | | |
| | | |

Account #: ______________________

## IMMUNIZATION HISTORY

Tetanus: _______within the last 10 years _______ unknown

Hepatitis B: _______childhood _______unknown _______other (please explain:_______________)

## FAMILY MEDICAL HISTORY

Please indicate the existence of the following conditions in your immediate family (parents, siblings, grandparents)

| Condition | Yes | No | Family Member |
|---|---|---|---|
| High Blood Pressure | | | |
| Heart Attack | | | |
| Stroke | | | |
| Diabetes | | | |
| Thyroid Disease | | | |
| Cancer: list below | | | |
| | | | |

## SOCIAL HISTORY

Do you currently smoke? ____No ____Yes If yes, Daily usage:________ Number of years: _____________

Use of e-cigarettes/vaping? ____No ____Yes

If no, have you ever smoked? ____No ____Yes

Do you drink alcohol? ____No ____Yes ____Socially If yes, list amount/frequency: ____________________

Illicit drug use? ____No ____Yes If yes, please list: _____________________________

## ALLERGIES

**Medication Allergies:** ______No ______Yes

**If yes, list medication(s) name & reaction(s):** ____________________________________________

____________________________________________

**Allergies to:** ______ Metal ______ Iodine ______ Shellfish ______ Latex ______None

**Unusual reaction to Anesthesia?:** ______No ______Yes ***If yes, describe symptom/reaction:***

____________________________________________

## CURRENT MEDICATION HISTORY

Please List **ALL** Medications you are presently taking (as well as over the counter, herbs, supplements)

☐ **NO MEDICATIONS**

| Medication | Dosage | Frequency | Prescribing Doctor |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Signed by:** ____________________________________________

**Patient/Guardian Signature**

**REVIEWED BY: (Office use only)**

| Date | Name |
|---|---|
| | |