

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.

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

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**
- | | | | | |
|--|-------------|----------------|------------------------|------------------|
| <input type="checkbox"/> Appendectomy | Year: _____ | Surgeon: _____ | | |
| <input type="checkbox"/> Bypass/Open Heart | Year: _____ | Surgeon: _____ | | |
| <input type="checkbox"/> Cataract Extraction | Year: _____ | Surgeon: _____ | | |
| <input type="checkbox"/> Cesarean Delivery | Year: _____ | Surgeon: _____ | | |
| <input type="checkbox"/> Gall Bladder | Year: _____ | Surgeon: _____ | | |
| <input type="checkbox"/> Hernia Repair | Year: _____ | Surgeon: _____ | | |
| <input type="checkbox"/> Hysterectomy | Year: _____ | Surgeon: _____ | | |
| <input type="checkbox"/> Tonsillectomy | Year: _____ | Surgeon: _____ | | |
| <input type="checkbox"/> Knee surgery | Year: _____ | Surgeon: _____ | Type of Surgery: _____ | ___Left ___Right |
| <input type="checkbox"/> Shoulder surgery | Year: _____ | Surgeon: _____ | Type of Surgery: _____ | ___Left ___Right |
| <input type="checkbox"/> Hip surgery | Year: _____ | Surgeon: _____ | Type of Surgery: _____ | ___Left ___Right |
| <input type="checkbox"/> Neck/Back surgery | Year: _____ | Surgeon: _____ | Type of Surgery: _____ | ___Left ___Right |
| <input type="checkbox"/> 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)

	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