

Medical History Form

Patient Name: _____ Age: _____ Date: _____

Family Physician_____
Family Physician Address(_____) _____
Physician Phone #

Who referred you to this office? _____

Referring Physician Address(_____) _____
Referring Physician Phone #

Height _____ Weight _____ Hand Dominance: Right Left

What are you here to see us for today? Right / Left _____

When did your problem start? _____ Is your problem work-related? Yes No

Have you seen another doctor for this problem? Yes No If yes, who? _____

Briefly describe how your injury occurred: _____

Please circle your current pain level: 0 1 2 3 4 5 6 7 8 9 10
*Mild Moderate Severe*Please list any previous Orthopaedic problems or Broken Bones **related** to the current condition
Date Condition/Injury Treatment (Surgery, Therapy)**ALLERGIES**

Are you allergic to any medications? Yes No

Please list: _____

Are you allergic to Latex? Yes No Are you allergic to anything else? Yes No Please List: _____

PAST MEDICAL HISTORY (Please check all current or previous medical Conditions)

<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV	<input type="checkbox"/> Seizures
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Immune System Disease	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> No Medical
<input type="checkbox"/> Depression	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Problems
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Other _____		

Do you have a history of Peptic Ulcer Disease? Yes No Stomach Bleeding? Yes No

Have you ever had a blood clot? Yes No In your legs? Yes No In your lungs? Yes No

Female Patients: Are you pregnant? Yes No Date of last menstrual period _____

Patient Name _____ Physician Signature _____ Date _____

PAST SURGICAL HISTORY (Please list all procedures with Date and Surgeon's Name)

Surgical Procedure	Date	Surgeon's Name
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list ALL MEDICATIONS that you are currently taking (Including Vitamins, Supplements, and Herbs)

I AM ON NO MEDICATIONS

Medication	Dosage	Reason for Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY MEDICAL HISTORY (Please check any conditions that run in your family)

Blood Clots Diabetes Hypertension Cancer Heart Disease
 Osteoporosis Stroke/Seizures Rheumatoid Arthritis No Significant Problems

Please describe any other Immediate Family history of medical problems: _____

SOCIAL HISTORY

Occupation: _____

Marital Status: Single Married Divorced Widowed

Education: Grade School High School College Post Graduate

Tobacco Use: Yes No Type: _____ # per day: _____ Quit date: _____

Alcohol Use: Yes No Type: _____ Frequency: _____

Drug Use: Yes No Type: _____ Frequency: _____

Exercise: Daily Weekly Monthly Rarely Never

Type of Exercise: _____

Do you have family/friends available to assist you at home? Yes No

Do you have steps to enter you home? Yes No

Do you have a bedroom & bathroom on your first floor? Yes No

How far can you walk before taking a rest period? Less than 1 block 2 Blocks Half Mile No Limits

Patient Name _____ Physician Signature _____ Date _____

Current Health Problems
(Please Circle ALL that apply)

General	Weight Loss	Weight Gain	Fatigue	Decreased Appetite	
	Chills	Fever	Sweats	Sleeping Difficulty	No Problem
Eyes	Blurred Vision/ Vision Loss	Eye Pain	Glasses/ Contacts	Glaucoma	No Problem
Ear, Nose, Throat	Hearing Loss	Dentures	Thyroid Enlargement	Throat Pain	
	Inflammation	Canker Sores	Swollen Glands		No Problem
Cardiovascular	High Cholesterol	Chest Pain	Palpitations	Heart Murmur	
	Heart Attack	Aortic Aneurysm	Leg Swelling	Shortness of Breath	No Problem
Respiratory	Sleep Apnea	Tuberculosis	Pneumonia	COPD	
	Emphysema	Wheezing	Sputum/ Phlegm	Coughing	No Problem
Gastrointestinal	Vomiting	Diarrhea	Hemorrhoids	Blood in Stool	
	Acid Reflux	Constipation	IBS	Stomach Ulcers	No Problem
Urinary	Blood in Urine	Incontinence	Bladder Infections or Burning	Kidney Stones	No Problem
Endocrine	High Blood Sugar	Thyroid Disease	Menopause		No Problem
Musculoskeletal	Injury	Joint Pain	Muscle Pain	Swelling	No Problem
Skin	Color Change	Rash	Cellulitis/ Infection	Breast Problems	No Problem
Neurologic	Dizziness	Fainting	Numbness	Stroke	No Problem
	Tingling	Headaches	Bad Balance	Trouble with Memory	No Problem
Hematologic/ Lymph	Leukemia	Anemia	Edema/ Swelling in Legs	Bleeding Disorders	No Problem
Immunologic	HIV	AIDS	Hepatitis	Sexually Transmitted Disease	No Problem
PSYCHOLOGICAL	Depression	Anxiety	Mania	Personality Disorder	No Problem
Other:					

Patient Name _____

Physician Signature _____

Date _____