

MEDICAL HISTORY

Patient Name _____ Date of Birth _____ Age _____

Patient's Employer/School _____

Athlete's Only: Name of Coach _____ Phone _____
Name of Trainer _____ Phone _____
Sport _____

Reason for today's visit _____

Family Physician _____ Referred By _____

Other Treating Physicians _____

Have you had x-rays taken of chief complaint? _____ Where? _____

Do you have them with you today? _____ Is this problem related to an accident? _____

CURRENT MEDICATION:

Medication	Dosage	Frequency	Medication	Dosage	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Are you Allergic to any medications? _____

PAST SURGERIES:

Type of Surgery	Year	Type of Surgery	Year
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY MEDICAL HISTORY: List medical illness affecting your immediate family.

Disease	Family Member	Disease	Family Member
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY: Check and fill in blanks.

___ Married ___ Single ___ Divorced ___ Live Alone # ___ Children ___ Pets

___ Alcohol: ___ Occasional ___ Daily ___ Heavy

___ Tobacco: ___ Yrs. Used ___ Packs per Day ___ Drugs

Examiners Signature _____

Date _____

Patient Name _____

Height _____

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Weight _____

Age _____

Briefly describe symptoms/injury: _____

GENERAL HISTORY: Answer YES or NO

General

- _____ 1. weight change
- _____ 2. fever or chills
- _____ 3. night sweats
- _____ 4. "free" bleeding
- _____ 5. lumps or masses
- _____ 6. dizziness or fainting
- _____ 7. itching or rash.
- _____ 8. diabetes mellitus
- _____ 9. thyroid problem
- _____ 10. cancer
- _____ 11. sickle cell
- _____ 12. anemia

Ear-Eye-Nose-Throat

- _____ 1. visual change
- _____ 2. hearing change
- _____ 3. tinnitus(ringing in ears)
- _____ 4. dentures
- _____ 5. bleeding gums
- _____ 6. hoarseness

Cardiovascular

- _____ 1. heart disease
- _____ 2. hypertension
- _____ 3. mitral valve prolapse
- _____ 4. thrombophlebitis/PE
blood clot
- _____ 5. chest pain

Respiratory

- _____ 1. cough/sputum
- _____ 2. rheumatic fever
- _____ 3. tuberculosis
- _____ 4. pleurisy/pneumonia
- _____ 5. shortness of breath
- _____ 6. asthma

Breast

- _____ 1. lumps,pain
nipple discharge
- _____ 2. surgical procedure

Gastrointestinal

- _____ 1. dysphagia(difficulty
in swallowing)
- _____ 2. nausea & vomiting
- _____ 3. jaundice
- _____ 4. hepatitis
- _____ 5. pancreatitis
- _____ 6. ulcers
- _____ 7. hemorrhoids

Genitourinary

- _____ 1. urinary infections
- _____ 2. urinary frequency
- _____ 3. incontinence
- _____ 4. sexual transmitted
disease(s)
- _____ 5. menopause
- _____ 6. prostate enlargement

Musculoskeletal

- _____ 1. backache
- _____ 2. joint pain
- _____ 3. joint swelling

Neurologic

- _____ 1. seizures
- _____ 2. paralysis
- _____ 3. numbness
- _____ 4. weakness
- _____ 5. strokes

Examiner's Signature _____

Date _____