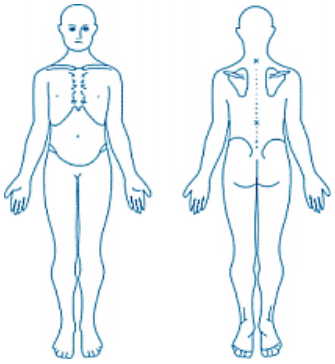
Medical History Form

Name: _____Age:_____DOB:_____Date:_____
Referred by:
Primary Care Physician Name:
Other Physician(s) involved in your care:
Describe the symptom/problem that you want the provider to address with you at this visit:

Which is your dominant hand? _____ Right _____ Left **Height: _____ Weight: _____**



Please indicate any pain, numbness, tingling, or weakness with an "X" on the diagram:

Is this the result of an accident? _____No _____Yes

Allergies to Medications: **_____ No Known Drug Allergies** (Please include any problems with anesthesia)

Medication Name	**Reaction**

Current Medications:

Drug Name/Dosage/Frequency	**Drug Name/Dosage/Frequency**

Past Medical History: Please check ongoing conditions or past problem(s):

Neurology
Dementia
Migraine
Aneurysm
Seizure/Epilepsy
Other:_____

Heart Disease
Heart Attack
Congestive Heart Failure
Rhythm Problem, Type: _____
Pacemaker

Genitourinary
Enlarged Prostate
Cancer: _____

Lung Disease
COPD
Asthma
Apnea
Cancer

Blood Disorder
Bone Marrow Disorder
Blood Clot/ Pulmonary Embolism

Connective Tissue Disease
Eczema/ Psoriasis
Lupus
Rheumatoid Arthritis

Psychiatric
Depression/Anxiety

Endocrine
Thyroid Disease, Type: _____
Diabetes
Pituitary

Gastrointestinal
Obesity
GERD
Peptic Ulcer Disease
IBS
High Cholesterol
Hepatitis

Other: _____

Previous Surgeries:

Family History: (Check any medical problems that exist in your family)
___Spinal Problems ___Neurological Disorders ___Aneurysm ___Stroke ___Heart Disease ___Hypertension
___Diabetes ___Bleeding Disorder ___Cancer (type):_____ Other: _____

Social History

Tobacco Use: (Please fill in and/or check as appropriate)

Never Smoked	Former Smoker:	Current Smoker:	Type:
	Pack/Day/Years:	Pack/Day/Years:	Cigarettes, Pipe, Cigar
	Quit Date:	**Ready to Quit?** **Yes No**	Snuff, Chew, Smokeless

Alcohol Use: (Please fill in and/or check as appropriate)

No	Yes
Amount Per week (0.5 oz)	Type: Wine Beer Liquor

Employment Status: (Please fill in and/or check as appropriate)

Retired	Homemaker	Student	Unemployed	Disability	Employed
Employer:_____			Occupation:_____		

Marital Status: (Please fill in and/or circle as appropriate)

Single	Married	Partnership	Divorced	Widowed	Spouse's Name:
Number Of children:			Years of Education: Under 12 12 14 16 18+		

Review of Systems (Please check any of the following you currently experience)

Constitutional
Appetite Change
Fatigue
Fever
Unexplained weight change

HENT
Neck Pain
Neck Stiffness
Hearing Loss
Tinnitus (ear ringing)
Nosebleeds
Dental Problem
Sore Throat
Trouble Swallowing
Voice Change

EYES
Photophobia (eye pain to light)
Visual Disturbance

Respiratory
Apnea (no breathing)
Chest Tightness
Choking
Cough
Shortness of Breath
Wheezing

Cardiovascular
Chest Pain
Leg Swelling
Palpitations

GI
Abdominal Pain
Constipation
Diarrhea
Nausea
Vomiting

GU
Dysuria (painful urination)
Flank Pain
Frequency
Hematuria
Urgency

MS
Arthralgias (joint pain)
Back Pain
Gait Problem
Joint Swelling
Myalgias (muscle pain)

Skin
Color Change
Rash
Wound

Neurological
Dizziness
Headaches
Lightheadedness
Numbness
Seizures
Speech Difficulty
Syncope (fainting)
Tremors
Weakness

Hematologic
Adenopathy (large lymph nodes)
Bruises/Bleeds Easily

Psychiatric
Agitation
Behavior problem
Confusion
Decreased concentration
Dysphonic mood (unhappiness)
Hallucinations
Hyperactive
Nervous/Anxious
Sleep Disturbance
Suicidal Ideas