

MEDICAL HISTORY

PATIENT NAME:			DATE:
Physician:		Referring MD:	Family MD:
Birthday:		Address:	Address:
Weight:	Height:	Age:	
<input type="checkbox"/> Left handed <input type="checkbox"/> Right handed		Phone:	Phone:

HISTORY OF PRESENT ILLNESS

Describe your problem or reason for your visit:		
Is this the result of an injury?	Date of injury:	Location of injury?
<input type="checkbox"/> YES <input type="checkbox"/> NO	How did injury occur?	

EVALUATION OF PAIN / DISCOMFORT

What body part is affected?				
When did the problem start?				
When does the problem occur?				
What makes it feel better?				
What makes it feel worse?				
How long does it last?				
Pain Scale	MILD	MODERATE	SEVERE	(Circle one number)
	NO PAIN 1 2 3	4 5 6	7 8 9	
What activities are you unable to do because of pain?				
Does the pain wake you from sleep? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is pain activity related? <input type="checkbox"/> YES <input type="checkbox"/> NO			

PREVIOUS TREATMENT FOR THIS PROBLEM

Diagnostic Testing:	<input type="checkbox"/> X-ray	<input type="checkbox"/> CT	<input type="checkbox"/> MRI	<input type="checkbox"/> EMG	<input type="checkbox"/> Other:
Medications:					
Anti-inflammatories	<input type="checkbox"/> Helpful	<input type="checkbox"/> Not helpful	Chiropractics	<input type="checkbox"/> Helpful	<input type="checkbox"/> Not helpful
Injections	<input type="checkbox"/> Helpful	<input type="checkbox"/> Not helpful	Accupuncture	<input type="checkbox"/> Helpful	<input type="checkbox"/> Not helpful
Physical Therapy	<input type="checkbox"/> Helpful	<input type="checkbox"/> Not helpful	Where:		
Other treatment for this injury:					
Have other doctors seen you for this condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, who?		
Is this condition being covered by Worker's Compensation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Is there a lawsuit or litigation pending in regard to this injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

PAST MEDICAL HISTORY

(Check all that apply)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bleeding tendencies	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Blood clots	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Stroke	<input type="checkbox"/> Cancer	<input type="checkbox"/> Vascular disease
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Anesthesia difficulties

PAST SURGICAL HISTORY (Check all that apply)

Describe:	Year:	Describe:	Year:
Describe:	Year:	Describe:	Year:
Describe:	Year:	Describe:	Year:

MEDICATIONS (List all prescription and non-prescription)

Name of Medication	Dose	How often?	Name of Medication	Dose	How often?

ALLERGIES (Medicines, metals, etc)

List:

FAMILY HISTORY (Check all that apply)

- Cancer
- Heart Disease
- Stroke
- Diabetes
- Malignant hyperthermia
- Bleeding disorder
- Musculoskeletal disease
- Anesthesia difficulties

SOCIAL HISTORY (Check all that apply)

<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
<input type="checkbox"/> Live alone	<input type="checkbox"/> Live with family	<input type="checkbox"/> Live with friends	<input type="checkbox"/> Nursing home
Smoking <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how many packs/day?		How many yrs?
Alcohol <input type="checkbox"/> None	<input type="checkbox"/> Minimal	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
Occupation:	Employer:	Last day worked:	

REVIEW OF SYSTEMS (Check all that apply)

Skin	<input type="checkbox"/> Rash	Throat	<input type="checkbox"/> Sore throat	GI	<input type="checkbox"/> Weight loss or gain
	<input type="checkbox"/> Psoriasis		<input type="checkbox"/> Hoarseness		<input type="checkbox"/> Abdominal pain
Heme	<input type="checkbox"/> Bleeding tendencies		<input type="checkbox"/> Snoring		<input type="checkbox"/> Liver disease
	<input type="checkbox"/> Bruise easily	CV	<input type="checkbox"/> Heart attack		<input type="checkbox"/> Constipation
Eyes	<input type="checkbox"/> Visual loss		<input type="checkbox"/> Irregular heartbeat	GU	<input type="checkbox"/> Kidney stones
	<input type="checkbox"/> Double vision		<input type="checkbox"/> Chest pain or pressure		<input type="checkbox"/> Bladder infections
Ears	<input type="checkbox"/> Decreased hearing	Lungs	<input type="checkbox"/> Shortness of breath		<input type="checkbox"/> Blood in urine
	<input type="checkbox"/> Ringing in ears		<input type="checkbox"/> Asthma	Endo	<input type="checkbox"/> Diabetes
Nose	<input type="checkbox"/> Sinus problems		<input type="checkbox"/> Bronchitis		<input type="checkbox"/> Thyroid
	<input type="checkbox"/> Breathing problems		<input type="checkbox"/> Pulmonary emboli / DVT	Skeletal	<input type="checkbox"/> Osteoporosis
Psych	<input type="checkbox"/> Depression	Neuro	<input type="checkbox"/> Seizures		<input type="checkbox"/> Rheumatoid Arthritis
	<input type="checkbox"/> Hallucinations		<input type="checkbox"/> Headaches		<input type="checkbox"/> Gout