

Patient Medical History

Patient name: _____

File number: _____

MEDICAL ILLNESSES

Do you have presently or have you ever been diagnosed with any of these illnesses?

- | | | | |
|--|---|--|--------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach Ulcers | Others _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Clots in Legs | _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Depression | _____ |

SURGICAL HISTORY

Have you ever had any of the following surgeries?

- | | | | |
|---|---|--|--------------|
| <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Arthroscopy | Others _____ |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Joint Replacement | _____ |
| <input type="checkbox"/> Gall Bladder Removal | <input type="checkbox"/> Fracture Surgery | <input type="checkbox"/> Spine Surgery | |

FAMILY HISTORY

Do any of the following medical problems run in your family?

- | | | | |
|--|--|--|--------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding Problems | Others _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | | _____ |

MEDICATIONS

Please list any medications that you take, including how much and how often if possible. Include over the counter medications and any supplements (glucosamine, ginkgo baloba, etc.) You may attach a list if you have one.

ALLERGIES

Are you allergic to any medications?

- | | | |
|-------------------------------------|-----------------------------------|--------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Aspirin | Others _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Novocain | _____ |

SOCIAL HISTORY

Please complete the following information:

- Do you smoke? yes no Occupation: _____
- Do you drink alcohol? yes no Single Married Separated Divorced Widowed

REVIEW OF SYSTEMS

Do you presently have any of the following problems?

- | | | | |
|--|---------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> breath | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Watery eyes | | <input type="checkbox"/> Indigestion | |
| <input type="checkbox"/> Blurry vision | | <input type="checkbox"/> Joint pain | |
| <input type="checkbox"/> Cough | | <input type="checkbox"/> Anxiety | |
| <input type="checkbox"/> Wheezing | | <input type="checkbox"/> Burning with | |
| <input type="checkbox"/> Shortness of | | urination | |

- Numbness
- Weakness
- Fainting spells
- Diarrhea
- Rashes
- Leg Swelling
- Seizures
- Constipation
- Skin Ulcers
- Problems sleeping
- Depression
- Joint Swelling

VITAL SIGNS

Pulse _____ Respirations _____ Blood pressure _____ / _____ Height _____
 Weight _____

HISTORY OF PRESENT ILLNESS

What problem(s) brought you into the doctor today? Check all that apply, write an R, L, or B (for right, left or both beside the body part if there is more than one area.

- Neck Back Shoulder Arm Shoulder Elbow Hand
- Hip Knee Ankle Foot Other _____
- Right Left Both Right worse than left Left worse than right Both same

When did it start? _____ Not sure _____ Months Days Wks before today

Did the problem start with an injury or accident? Yes No Did it occur at work? Yes No

Describe the pain: Sharp Dull Intermittent Constant Other _____

Check all that apply: Burning One area Multiple areas

How severe is the pain on a scale of 1 to 10 with 10 being the worst pain imaginable?

Circle one 0 1 2 3 4 5 6 7 8 9 10

What makes the problem worse? _____

What makes the problem better? _____

Does the problem/pain occur at any particular time of the day? yes no Not sure

If so when does it occur? (check all that apply) morning during day After work At night
 All the time Other _____

Have you been seen or **treated** for this problem before? Yes No

If so, by whom? _____

What treatments have you had? None Medicine Physical Therapy Surgery Other _____

Did any of these treatments help? Yes Yes, but it came back Partially No

Have you had anything like this in the past? Yes No Not sure

<p><i>On the picture below, please place an "x" on the areas where you feel pain.</i></p>	<p>NOTES: <i>(Staff use only)</i></p>	<p>Reviewed by:</p> <p>Initials</p> <p>1.</p> <p>2.</p> <p>3.</p> <p>4.</p> <p>5.</p> <p>6.</p> <p>7.</p> <p>8.</p> <p>9.</p> <p>10.</p> <p>Date</p>
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