Medical History Form

Name _____ Date _____ Ht _____ Wt _____Age _____DOB _____
Date of Injury _____ Referred By _____ Family Physician _____
Chief Complaint _____Pain Scale (1-10, 1 being least amount of pain) _____
Alleviating Factors _____Aggravating Factors_____
Details of Injury (How? Where? Any Treatment?) _____

Medical History (High Blood Pressure, Diabetes, Emphysema, Gastric Reflux, etc.) _____

Pharmacy Name, Address and Phone Number _____

PATIENT MEDICATIONS

FAMILY HISTORY			
Member	Alive/ Dead	Age	Health Status
Grandmother (mom's)	A D		
Grandfather (mom's)	A D		
Grandmother (dad's)	A D		
Grandfather (dad's)	A D		
Father	A D		
Mother	A D		
Sister/ Brother	A D		
Sister/ Brother	A D		
Sister/ Brother	A D		
Sister/ Brother	A D		

PATIENT SURGERIES	YEAR	SURGEON/ HOSPITAL

METAL & DRUG ALLERGIES

_____
_____
_____
_____

Have you ever had general anesthesia? Y/N **Have any problems with anesthesia? Y/N _____**

REVIEW OF SYSTEMS (Please check if you are currently or have had problems with these & describe)					
Eyes	Y / N	Diabetes	Y / N	Arthritis	Y / N
Ears, Nose, Throat	Y / N	High Blood Pressure	Y / N	Strokes	Y / N
Lungs/ Breathing	Y / N	Bleeding Problems	Y / N	Hepatitis	Y / N
Chest Pain/ Heart Problems	Y / N	Balance Problems	Y / N	Tuberculosis	Y / N
Ulcers	Y / N	Numbness/ tingling	Y / N	Seizures	Y / N
Bowel Movement	Y / N	Blackout/ fainting	Y / N	Blood Clots	Y / N
Bladder Problems	Y / N	Depression	Y / N	Cancer	Y / N

SOCIAL HISTORY

Marital Status: S M D W **Do you live alone? Y / N** **Exercise Regularly (times/week) _____ Type _____**
Smoke: Y / N **Packs per day_____ How many years_____Alcohol use: Y / N** **Drinks per day_____**
Drug use: Y / N **What? _____ Years _____** **Drug Rehab: Y / N**
Do you use assistive device (cane, walker, etc.) for ambulation? Y / N
If yes, what type and how long? _____
Occupation _____ Who do you work for? _____
Dominant Hand? Right or Left
Where do you live? (Home, Nursing Home, Relatives, etc.) _____
Patient Signature _____

Physician Notes: