

Complete Medical History

Name: _____ Date: _____

Date of birth: _____ Age: _____ Occupation: _____

Employer: _____ Describe your job: _____

Personal physician: _____ Send a report to your physician? () No () Yes

CURRENT PROBLEM: _____

Date symptoms began?: _____ Duration: _____
Location: - _____ Severity of Pain: None 1 2 3 4 5 6 7 8 9 10 (severe)

Anything help symptoms: _____

Is the pain (circle one) all the time or some of the time
Is the pain (circle one) dull achy burning throbbing sharp & stabbing

HOW DID THE SYMPTOMS OR INJURY OCCUR?: _____

ANY PREVIOUS SIMILAR PROBLEMS?: _____

Is this due to INJURY? () NO () YES DATE OF INJURY: _____
Is this WORK RELATED? () NO () YES Has injury been REPORTED? () NO () YES
Are you WORKING NOW? () NO () YES Caused you to MISS Work? () NO () YES

PREVIOUS TREATMENT FOR THIS INCLUDING DIAGNOSTIC PROCEDURES, (x-rays, EMG's, physical therapy, MRI, Labs) _____

HEIGHT: _____ WEIGHT: _____ BMI _____ (office use)

DO YOU HAVE ANY ALLERGIES TO MEDICATION or FOODS? () NONE KNOWN
MEDICATION REACTION MEDICATION REACTION

DO YOU HAVE ANY REACTIONS TO LATEX GLOVES OR LATEX PRODUCTS? () NO () YES

DO YOU HAVE A SENSITIVITY OR ALLERGY TO METAL? () NO () YES

LIST ALL THE MEDICATIONS YOU ARE TAKING (INCLUDING SUPPLEMENTS AND OVER THE COUNTER)
() NONE

NAME	DOSAGE	NAME	DOSAGE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LIST ALL THE SURGERIES YOU HAVE HAD AND THEIR DATES: () None

NAME OF SURGERY	DATE	NAME OF SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY: Please complete the following information regarding your medical history and family history: Place a check mark in the column labeled you if you have ever had the following condition. **Please place an M for mother, F for father, G for grandparent, S for sister and B for brother in the family column if any of your family members have or ever had the following conditions.**

Topic	Family	You	Topic	Family	You
General			GastroIntestinal GI		
Cancer			Ulcers		
Diabetes *			Bowel disease		
High Blood pressure			IBS		
Thyroid *			Diarrhea or Constipation *	-----	
Anemia	-----		Jaundice		
Skin Conditions *	-----		OTHER		
Environmental Allergies *	-----		GenitoUrinary GU		
OTHER			Bladder or kidney infections		
Neurologic			Kidney problems		
Seizures			Prostate problems		
Headaches *	-----		Urinary Incontinence *	-----	
Head Trauma	-----		OTHER		
Weakness & Tingling *	-----		Musculoskeletal		
Numbness *	-----		Fibromyalgia		
Neurological problems			Generalized Achiness *	-----	
Stroke			Osteoporosis		
Sciatica			Arthritis		
OTHER			Rheumatoid arthritis		
HEENT			Gout		
Vision Problems *	-----		Lupus		
Hearing Problems *	-----		Lyme's Disease		
Glaucoma			Blood clot		
Cataracts	-----		Back pain *	-----	
OTHER			Scoliosis		
Cardiovascular/ Respiratory			OTHER		
Cardiac pacemaker			Fractures	-----	
Heart Disease			Dislocations	-----	
Angina/Chest pain *					
Heart attack			Infectious Disease Exposure		
Rheumatic fever	-----		Hepatitis A, B, C or D		
Bleeding tendency *			HIV		
Circulation problems *			Tuberculosis TB		
shortness of breath *	-----		MRSA INFECTION		
Asthma			Psychological		
Pneumonia	-----		Depression *		
Sleep Apnea			Compulsive disorder *		
Emphysema			OTHER		

IS THERE A POSSIBILITY YOU MAY BE PREGNANT? () NO () YES
 HAVE YOU EVER HAD BLOOD TRANSFUSION? () NO () YES
 HAVE YOU HAD ANY PROBLEMS WITH ANESTHESIA? () NO () YES
 HAVE YOU EVER BEEN ON STEROID or CORTISONE MEDICATION? () NO () YES

SOCIAL HISTORY:

Do you use: Alcohol Yes () No () Tobacco: Yes () No () (If yes, packs per day _____)

Living arrangements: House _____ Stairs? Yes () No () Apartment _____ Do you live alone? Yes () No ()

Hobbies/activities: _____

Patient signature _____ I have reviewed the above information with the patient
 * conditions denote Review of Systems

Physician signature: