

MEDICAL HISTORY

Patient Name _____ Today's Date _____ Date of Birth _____

CC: Describe what brings you to the office today: _____

HPI: Where exactly is the problem located? _____

How long has this been bothering you? _____

What treatment have you had for this? _____

What makes it better? _____

What makes it worse? _____

Is this problem caused by an injury? If so was it on the job? _____

If it was on the job did you report the injury? _____

PMH: Do you have or have you ever been treated for: (ONLY INDICATE POSITIVES)

- | | | | |
|------------------------|---------------------------|-------------------------|-----------------------|
| ____ Sinus problems | ____ Stomach Ulcer | ____ Anemia | ____ Rheumatic Fever |
| ____ Eye Disorders | ____ Hiatal Hernia | ____ Blood Disorder | ____ Lupus |
| ____ Ear problems | ____ Colitis | ____ Sickle Cell Anemia | ____ Scarlet Fever |
| ____ Throat conditions | ____ Frequent Indigestion | ____ Diabetes | ____ Strep Infections |

- | | | | |
|--------------------------|---------------------------|----------------------------------|-----------------------|
| ____ Asthma | ____ Osteoporosis | ____ Hepatitis | ____ Venereal Disease |
| ____ Shortness of Breath | ____ Osteoarthritis | ____ Gout | ____ HIV |
| ____ Emphysema | ____ Rheumatoid Arthritis | ____ Liver Disease | |
| ____ Tuberculosis | ____ Fibromyalgia | ____ Thyroid Disease | |
| ____ Lung Cancer | ____ Joint Swelling | ____ Kidney Disease | |
| | | ____ Cancer (specify Type _____) | |

____ Fractures of the foot, ankle or leg _____

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|---------------------------------|-----------------------------|--------------------------|
| ____ Stroke | ____ Nerve Disorder | ____ Psoriasis |
| ____ Heart Attack | ____ Headaches | ____ Eczema |
| ____ High Blood Pressure | ____ Alzheimer's | ____ Skin Condition |
| ____ Heart Condition | ____ Tarsal Tunnel syndrome | ____ Hives |
| ____ Chest Pain (Angina) | ____ Carpal Tunnel syndrome | ____ Keloid / Thick Scar |
| | ____ Low back pain | ____ Skin Cancer |
| ____ Free Bleeding | ____ Sciatica | |
| ____ Phlebitis (Blood Clotting) | ____ Epilepsy | |
| ____ Leg Cramps | ____ Psychiatric Disorder | |
| ____ Poor Circulation | | |

Ever had **surgery**..... ____ No ____ Yes

If yes: Type of Surgery _____ Year performed _____

Type of Surgery _____ Year performed _____

Type of Surgery _____ Year performed _____

Type of Surgery _____ Year performed _____

Family History: Have you or any of your FAMILY members had?

- | | |
|--------------------|--------------------------|
| ____ Diabetes | ____ Heart Disease |
| ____ Arthritis | ____ High Blood Pressure |
| ____ Cancer | ____ Free Bleeding |
| ____ Birth Defects | |

WOMEN ONLY: # of childbirths _____ Are you currently pregnant? _____

PLEASE FILL OUT OTHER SIDE OF THIS FORM

PAGE 2 MEDICAL HISTORY FOR _____ CONTINUED

SOC HX: Do you use tobacco products? _____ No _____ Yes
 If yes, what do you use? _____
 How often and how much? _____

Do you drink Alcohol? _____ No _____ Yes
 If yes, what do you drink? _____
 How often and how much? _____

MEDS: Are you currently taking any medications? _____ No _____ Yes (If yes, list below)

List any medication you take on a regular basis including vitamins, holistic, and over the counter drugs as well as prescriptions:

Medications	How Often	For How Long
Dose	(X Daily, X Weekly)	(weeks, months, years)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES OR REACTIONS:

If yes, describe the reaction:

Penicillin..... No _____ Yes _____
 Keflex..... No _____ Yes _____
 Sulfa..... No _____ Yes _____
 Other Antibiotics (List here) _____
 Morphine..... No _____ Yes _____
 Codeine..... No _____ Yes _____
 Demerol..... No _____ Yes _____
 Darvon..... No _____ Yes _____
 Vicodin..... No _____ Yes _____
 Lorcet..... No _____ Yes _____
 Aspirin..... No _____ Yes _____
 Tylenol..... No _____ Yes _____
 Motrin/Advil..... No _____ Yes _____
 Other Pain Medicines: (List here) _____
 Local anesthetics..... No _____ Yes _____
 Adhesive tape..... No _____ Yes _____
 Iodine, Merthiolate, or Betadine ___ No _____ Yes _____
 Naprosyn..... No _____ Yes _____
 Feldene..... No _____ Yes _____
 Indocin..... No _____ Yes _____
 Alleve..... No _____ Yes _____
 Vioxx..... No _____ Yes _____
 Celebrex..... No _____ Yes _____
 Other anti-inflammatory medications (List here) _____

Is there anything else in your medical history you want the doctor to be aware of?

Signature _____

Date _____