MEDICAL HISTORY

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

What brings you to the office today? _____

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? _____

What sports do you play? _____

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

- ☐ Sinus problems
- ☐ Eye Disorders
- ☐ Ear problems
- ☐ Lupus
- ☐ Stomach Ulcer
- ☐ Hiatal Hernia
- ☐ Colitis
- ☐ Frequent Indigestion
- ☐ Nerve Disorder
- ☐ Tarsal Tunnel
- ☐ Sciatica
- ☐ Low back pain
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Asthma

- ☐ Anemia
- ☐ Blood Disorder
- ☐ Sickle Cell Anemia
- ☐ Sickle Cell Trait
- ☐ Clotting Disorder
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Joint swelling
- ☐ Hepatitis
- ☐ Gout
- ☐ Liver Disease
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ Psoriasis
- ☐ Eczema
- ☐ Skin Condition
- ☐ Keloid / Thick Scar
- ☐ Skin Cancer

- ☐ Cancer (specify Type) _____
- ☐ Fractures of the foot, ankle or leg _____

- ☐ Stroke
- ☐ Heart Attack
- ☐ Heart Condition
- ☐ Chest Pain (Angina)
- ☐ High Blood Pressure
- ☐ Phlebitis/Blood Clots
- ☐ Leg Cramps
- ☐ Poor Circulation
- ☐ Alzheimer's
- ☐ Psychiatric Disorder
- ☐ Hives
- ☐ STD
- ☐ HIV
- ☐ Diabetes

Ever had **surgery:** ☐ No ☐ Yes

Type of Surgery		Year performed	
Type of Surgery		Year performed	
Type of Surgery		Year performed	
Type of Surgery		Year performed	

Please indicate if any IMMEDIATE family members have one of the following, and their relationship to you:

☐ Diabetes		☐ Heart Disease	
☐ Arthritis		☐ High Blood Pressure	
☐ Cancer		☐ Free Bleeding	
☐ Birth Defects			

WOMEN ONLY: # of childbirths _____ Are you currently pregnant? ☐ No ☐ Yes

PLEASE FILL OUT OTHER SIDE OF THIS FORM

PAGE 2 MEDICAL HISTORY FOR _____

Do you use **tobacco** products? ☐ No ☐ Yes If yes, what do you use? _____

How often and how much? _____

If no, have you ever smoked? ☐ No ☐ Yes If yes, when did you quit? _____

Are you exposed to secondhand smoke? ☐ No ☐ Yes

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

How often? ☐ Rarely ☐ Socially ☐ Former Drinker ☐ Recovering Alcoholic

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:

Medication	**Dose**	**How Often (once or twice daily, weekly)**	**For How Long (# of weeks / 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	
Hydrocodone/Vicodin/Lorcet	☐ No ☐ Yes	
Oxycodone/Percocet	☐ No ☐ Yes	
Aspirin	☐ No ☐ Yes	
Tylenol	☐ No ☐ Yes	
Other Pain Medicines: (List here)		
Motrin/Advil	☐ No ☐ Yes	
Feldene	☐ No ☐ Yes	
Indocin	☐ No ☐ Yes	
Aleve/Naprosyn	☐ No ☐ Yes	
Celebrex	☐ No ☐ Yes	
Other anti-inflammatory (List here)		
Local anesthetics	☐ No ☐ Yes	
Adhesive tape	☐ No ☐ Yes	
Iodine, Merthiolate, or Betadine	☐ No ☐ Yes	
Latex	☐ No ☐ Yes	

- if latex sensitive, can we use latex gloves when we treat you? ☐ No ☐ Yes

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

_____

Signature_____ **Date** _____