Patient Medical History

Name:		MRNO:	
Date:		Referred By:	

CHIEF COMPLAINT	
Why are you here today?	
Which side is involved? ☐ Right ☐ Left ☐ Both	Pain scale: (least) 1 2 3 4 5 6 7 8 9 10 (worst)
Describe your pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Throbbing	
What makes it better?	
What makes it worse?	
Do your symptoms? ☐ Interfere with normal activities ☐ Interefere with sports ☐ Interefere with work	
Are your symptoms present? ☐ All the time ☐ At night ☐ At rest ☐ With activity	
Do you experience any? ☐ Numbness ☐ Tingling ☐ Radiations ☐ Stiffness	

MEDICATIONS			
Please bring all medications to your appointment			
	Medication	Dose/Frequency	Reason for taking
1.			
2.			
3.			
4.			
5.			
6.			
☐ Vitamins	☐ Glucosamine/chondroitin	☐ Other supplements	☐ Baby / regular aspirin daily

ALLERGIES						
Are you allergic to any of the following?				☐ **No Known Drug Allergies**		
(Check all that apply)	Itch	Rash	Muscle soreness	Stomach problems	Difficulty breathing	Other
☐ Latex	☐	☐	☐	☐	☐	
☐ Codeine	☐	☐	☐	☐	☐	
☐ Sulfa	☐	☐	☐	☐	☐	
☐ Penicillin	☐	☐	☐	☐	☐	
☐ Keflex	☐	☐	☐	☐	☐	
☐ Steroid injections	☐	☐	☐	☐	☐	
☐ Shellfish	☐ Iodine	☐ Dye/contrast	☐ Eggs	☐ Tape/adhesive		
Other allergies:						
Serious side effects?						

OPTIONAL In the event it would become necessary to provide a copy of your medical records to another health care provider, including your primary care physician, please sign below authorizing the release of your records for this purpose.

Signature:		Date:	

Name:		MRNO:	

SURGERIES / HOSPITALIZATIONS				
	Type of Surgery	Year	Surgeon?	Where?
1.				
2.				
3.				
4.				
5.				
Have you ever had general anesthesia?	☐ Yes ☐ No			
Have any problems with anesthesia?	☐ Yes ☐ No			

SOCIAL HISTORY						
Occupation:		Employed By:				
Work Status:	☐ Full Time	☐ Part Time	☐ Restricted			
☐ Disabled	☐ Retired	☐ Work At Home	☐ Student			
Marital Status:	☐ Single	☐ Married	☐ Partnered	☐ Divorced	☐ Separated	☐ Widowed
Children:	☐ No	☐ Yes	How Many?	Do you live alone?	☐ No ☐ Yes	
Exercise?	☐ Daily	☐ Weekly	☐ Rarely	☐ Never		
What type of exercise?						
Are you on a special diet?	☐ No ☐ Yes	Describe:				
History of substance abuse?	☐ No ☐ Yes	Describe:				
Smoke currently? ☐ Never	☐ No ☐ Yes	Packs per day for years.				
Quit smoking?	☐ This year	☐ Last year	☐ What year?			
Previously smoked	Packs per day for	years.				
Drink alcohol?	☐ Never	☐ Daily	☐ 1-2x per week	☐ How much?		

FAMILY HISTORY					
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		
Are there any diseases that "run" in your family? (If so, please list)					

Name:		MRNO:	

MEDICAL HISTORY / SYSTEMS REVIEW

General	Yes	No
Fever		
Sweats		
Weakness		
Fatigue		
Chills		
Unexplained weight loss / gain		

Cardiovascular	Yes	No
High blood pressure		
Coronary disease		
Heart attack / MI		
Chest pain		
Shortness of breath		
Heart murmur		
Swollen ankles		
Pacemaker		
Congenital defect		

Respiratory	Yes	No
Asthma		
COPD / emphysema		
Bronchitis		
Shortness of breath		
Cough		
Tuberculosis / TB		

Endocrine	Yes	No
Diabetes		
Hyperthyroidism (High)		
Hypothryroidism (Low)		
High Cholesterol		

Broken Bones (Please List)

Hematologic	Yes	No
Easy bruising		
Anemia		
Blood clots		
Pulmonary embolus		
Hemophilia		
Transfusions		
Swollen glands		

Gastrointestinal	Yes	No
GERD / Reflux		
Hepatitis		
Irritable bowel		
Ulcer		
Diarrhea		
Constipation		
Jaundice		
Cirrhosis		
Liver failure		
Diverticulosis		
Gall bladder disease		

Neurologic	Yes	No
Stroke / CVA		
Seizure / epilepsy		
Headache / migraine		
Neuropathy		
Numbness / tingling		
Weakness		
Paralysis		
Dominant hand: ____Right ____Left		

Ear, nose, throat, eyes	Yes	No
Wear glasses		
Cataracts		
Glaucoma		
Sinusitis		
Seasonal allergies / AR		
Blurred vision		
Nosebleeds		
Hearing loss		

Musculoskeletal	Yes	No
Rheumatoid arthritis		
Osteoarthritis		
Lupus / SLE		
Gout		
Fibromyalgia		
Trigger points		
PMR		
Polio		
Psoriasis		
Low back pain		

Renal / Kidney	Yes	No
Kidney stones		
Bladder infection		
Blood in urine		
Frequency		
Urgency		
Hesitancy		
Kidney failure		
Dialysis		

Psychiatric	Yes	No
Depression		
Anxiety		
Bipolar		
Mood disorder		
Schizophrenia		
Drug abuse		
Alcohol abuse		

Infection	Yes	No
HIV		
AIDS		
HTLV		
Hepatitis		
Osteomyelitis		

Please list any additional medical problems that you feel we should know about:

Reviewed by ___________ /____________