Medical History Information Sheet

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

DOB: _____ **Age:** _____ **Height:** _____ **Weight:** _____

Visit Information

Reason for visit: _____ Referring Physician: _____

Primary Care Physician: _____

Type of pain: ☐ Ache ☐ Stabbing ☐ Throbbing ☐ Shooting ☐ Dull ☐ Click / Pop Date of Injury: ___/___/___

Severity: None 0 1 2 3 4 5 6 7 8 9 10 Intolerable Duration of pain: _____ Location of pain: _____

Pain Aggravated By:

☐ Standing ☐ Walking ☐ Lying
☐ Sleeping ☐ Working ☐ Stairs
☐ Sitting ☐ Driving

Treatments Attempted:

☐ Pain Medications ☐ Anti-Inflammatory ☐ Rest
☐ Wheelchair ☐ Physical Therapy ☐ Ice
☐ Surgery ☐ **NONE**

Current Health

Please list any health problems that you are currently diagnosed with.

☐ Seizures ☐ Lung Disease ☐ High Blood Pressure ☐ Thyroid Problems ☐ Pulmonary Embolism
☐ Liver Disease ☐ Heart Disease ☐ Cancer ☐ Stomach Ulcers ☐ DVT (Blood Clots)
☐ Osteoarthritis ☐ Asthma ☐ Diabetes ☐ Kidney Disease ☐ Rheumatoid Arthritis
☐ Chronic Headache ☐ Depression ☐ Gout ☐ High Cholesterol ☐ Jaundice
☐ Infections: Please explain: _____ ☐ _____
☐ Other Illness: Please explain: _____ ☐ _____

Females Only:

Date of Last Menstrual Period: ___/___/___ Currently Pregnant? ◯ Yes ◯ No ◯ Possibly

Surgical History

Please list any previous surgeries and approximate dates of surgery

Surgery:	Date:	Surgery:	Date:
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	☐ **NONE**	

Known Allergies to Anesthesia: ◯ No ◯ Yes Describe: _____

Medications

Please list any medications that you currently use, including over-the-counter medications, vitamins, herbs, and prescribed drugs.

Medication:	Dose:	Medication:	Dose:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	☐ **NONE**	

Allergies

Known Drug Allergies:

☐ **None Known** ☐ Iodine ☐ Diagnostic Dyes ☐ Morphine
☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Ibuprofen
☐ Sulfa Drugs ☐ Acetaminophen ☐ Latex ☐ Metal
☐ Other: _____

PLEASE TURN OVER

Family History

Problem:	Does it run in your family?		Please list family Member(s) who have had health issue and indicate maternal or paternal				
Diabetes	○ Yes	○ No	_____	Arthritis	○ Yes	○ No	_____
Heart Disease	○ Yes	○ No	_____	Hip Problems	○ Yes	○ No	_____
Asthma	○ Yes	○ No	_____	Cancer	○ Yes	○ No	_____
Blood Clots	○ Yes	○ No	_____				

Social History

Occupation: Current: _____ ☐ Disabled Reason for Disability: _____

Past: _____ ☐ Retired _____

Do you live alone: ○ Yes ○ No With Whom: _____

Do you smoke? ○ Yes ○ No _____ Packs / Day Quit: _____ Months Ago _____ Years ago

Do you drink alcohol? ○ Yes ○ No ○ Daily ○ Weekly ○ Monthly ○ Infrequently

Any recreational drug use? ○ Yes ○ No Please List: _____

Review of Systems:

Please check any that apply.

General	☐ Weight Loss	☐ Weight Gain	☐ Fatigue	☐ Decreased Appetite
	☐ Chills	☐ Fever	☐ Sweats	
Eyes	☐ Blurred Vision	☐ Pain	☐ Sore	☐ Vision Loss
	☐ Glaucoma	☐ Glasses	☐ Contacts	
Ear, Nose, Throat	☐ Hearing Loss	☐ Sore	☐ Inflammation	☐ Dentures
Cardiovascular	☐ High Cholesterol	☐ Chest Pain	☐ Palpitations	☐ Heart Murmur
	☐ Heart Attack	☐ Aortic Aneurysm	☐ Leg Swelling	☐ Shortness of Breath
Respiratory	☐ Sleep Apnea	☐ Tuberculosis	☐ Pneumonia	☐ COPD
	☐ Emphysema	☐ Wheezing	☐ Sputum	☐ Coughing
Gastrointestinal/	☐ Bladder Infections	☐ Burning	☐ Hemorrhoids	☐ Kidney Stones
Urinary	☐ Blood in Urine	☐ Incontinence	Last Colonoscopy - Date _____	
Musculoskeletal	☐ Injury	☐ Joint Pain	☐ Muscle Pain	☐ Swelling
Skin/Breasts	☐ Color Change	☐ Rash	☐ Cellulitis	☐ Breast Problems
	☐ Bruises	☐ Open Wound	Last Mammogram - Date _____	
Neurologic	☐ Dizziness	☐ Faint	☐ Numbness	☐ Stroke
	☐ Tingling	☐ Headaches	☐ Bad Balance	☐ Trouble with Memory
Hematologic / Lymph	☐ Leukemia	☐ Edema	☐ Anemia	☐ Bleeding Disorders
Immunological	☐ HIV	☐ AIDS	☐ Hepatitis	☐ Sexually Transmitted Diseases
Psychological	☐ Depression	☐ Anxiety	☐ Manic	☐ Personality Disorders
	☐ Night Sweats	☐ Sleep Disturbances		

Other important health information: _____

Signature

Patient Signature _____ **Date** _____