Medical History

Patient Name:		DOB:	Date:
Referring MD:		Family MD:	
[ ] Right-Handed	[ ] Left-Handed	Height:	Weight:

History of Present Illness

Describe your problem or Reason for your visit:	
Is this the result of an injury? [ ] Yes [ ] No	Date of Injury: Where did injury occur?: How did the injury occur?:

Evaluation Of Pain / Discomfort

What body part is affected?
When did the problem start?
When does the problem occur?
What makes it feel better?
What makes it feel worse?
How long does it last?

Pain Scale: | **Mild** **Moderate** **Severe** | Enter your score:
No Pain 1 2 3 4 5 6 7 8 9 10

What activities are you unable to do?
Does the pain wake you from sleep? [ ] Yes [ ] No | Is pain activity related? [ ] Yes [ ] No

Previous Treatment For This Problem

Diagnostic Testing: [ ] X-Ray [ ] CT [ ] MRI [ ] EMG [ ] Other:
Medications Used:
Anti-inflammatories helpful? [ ] Yes [ ] No [ ] N/A | Chiropractics helpful? [ ] Yes [ ] No [ ] N/A
Injections helpful? [ ] Yes [ ] No [ ] N/A | Acupuncture helpful? [ ] Yes [ ] No [ ] N/A
Physical Therapy helpful? [ ] Yes [ ] No [ ] N/A Where?
Other Treatment for this injury?
Have other doctors seen you for this condition? [ ] No [ ] Yes Whom?
Is this condition covered by Worker's Compensation? [ ] Yes [ ] No
Is there a lawsuit or litigation pending in regard to this injury? [ ] Yes [ ] No

Past Medical History

[ ] I have no significant past medical history
OR...I have a history of one or more of the following:

[ ] Eye Disease

[ ] Asthma
[ ] COPD
[ ] Emphysema
[ ]Tuberculosis
[ ]Sleep Apnea

[ ] Angina
[ ] Heart Disease
[ ] Heart Attack
[ ] High Cholesterol
[ ] Hypertension
[ ] Mitral Valve Prolapse

[ ] AIDS/HIV
[ ] Anemia
[ ] Bleeding Disorders
[ ] Blood Clots
[ ] Hemophilia
[ ] MRSA
[ ] Sickle Cell Disease

[ ] Bowel Disease
[ ] GERD
[ ] Hiatal Hernia
[ ] Kidney Disease
[ ] Urinary Tract Infection

[ ] Cancer
Type:

[ ] Cerebral Palsy
[ ] Meningitis
[ ] Migraine Headaches
[ ] Multiple Sclerosis
[ ] Parkinson's Disease
[ ] Polio
[ ] Seizure Disorder
[ ] Spina Bifida
[ ] Stroke

[ ] Back Problems
[ ] Fibromyalgia
[ ] Muscular Diseases
[ ] Scoliosis

[ ] Gout
[ ] Osteoarthritis
[ ] Osteoporosis
[ ] Rheumatoid Arthritis

[ ] Hepatitis { }A { }B { } C
[ ] Liver Disease

[ ] Alcohol Abuse
[ ] Anxiety
[ ] Bipolar Disorder
[ ] Depression
[ ] Drug Abuse
[ ] Mental Disability

[ ] Diabetes
[ ] Lupus
[ ] Thyroid Disease

[ ] Anesthesia Complications
[ ] Malignant Hyperthermia

Other:

Current Medications

[ ] I am not currently taking any medications
*** *Or please prepare a list of medications to give to the nursing staff when they interview you.*

Allergies

[ ] I have no known medical allergies of which I am aware.
*** *Or I am allergic to the following:*

	Reaction		*Reaction*		*Reaction*
[ ] Adhesive		[ ] Dilaudid		[ ] Macrobid	
[ ] Amoxicillin		[ ] Doxycycline		[ ] Morphine	
[ ] Aspirin		[ ] Erythromycin		[ ] Naprosyn	
[ ] Augmentin		[ ] Vicodin		[ ] Oxycodone	
[ ] Bactrim		[ ] Ibuprofen		[ ] Penicillin	
[ ] Bee Sting		[ ] Iodine		[ ] Shellfish	
[ ] Benadryl		[ ] Keflex		[ ] Statins	
[ ] Codeine		[ ] Latex		[ ] Sulfa	
[ ] Contrast Dye		[ ] Levaquin		[ ] Tetracycline	
[ ] Demerol		[ ] Lisinopril		[ ] Tramadol	
[ ] Other		[ ] Other		[ ] Other	

Past Surgical History

[ ] I have had no significant past surgeries
*** *Or the surgeries I have had are:*

Family Medical History

[ ] I have no significant family medical history [ ] Unknown
*** *Or my family has a history of:*

[ ] Arthritis	[ ] Bleeding Disorder	[ ] Blood Clot	[ ] Cancer	[ ] Diabetes
[ ] Epilepsy	[ ] Heart Disease	[ ] Hypertension	[ ] Kidney Disease	[ ] Lung Disease
[ ] Mental Illness	[ ] Muscle Disease	[ ] Osteoporosis	[ ] Scoliosis	[ ] Stroke
[ ] Anesthesia Complications				

Other:

Social History

Smoking Status: [ ] Never [ ] Ex-Smoker [ ] Smoker **Type:** [ ] E Cigarette [ ] Cigarette [ ] Pipe [ ] Cigar [ ] Smokeless [ ] Chew
*** If quit - When:
How often do you drink Alcohol: [ ] Never [ ] Occasionally [ ] Frequently [ ] Heavily

Review Of Systems

[ ] I have no current issues other than the reason I am being seen.
*** *Or I am currently having problems with the issue(s) selected below:*

Unexplained Weight Loss	[ ] Yes	[ ] No	[ ] Unsure
Fever	[ ] Yes	[ ] No	[ ] Unsure
Chills	[ ] Yes	[ ] No	[ ] Unsure
Fatigue	[ ] Yes	[ ] No	[ ] Unsure
Night Sweats	[ ] Yes	[ ] No	[ ] Unsure
Double Vision/Blackouts /Headaches	[ ] Yes	[ ] No	[ ] Unsure
Blurred Vision	[ ] Yes	[ ] No	[ ] Unsure
Difficulty Hearing	[ ] Yes	[ ] No	[ ] Unsure
Pain/Ringing in Ears	[ ] Yes	[ ] No	[ ] Unsure
Swollen Neck Glands	[ ] Yes	[ ] No	[ ] Unsure
Abdominal Pain/Nausea /Vomiting	[ ] Yes	[ ] No	[ ] Unsure
Trouble Swallowing	[ ] Yes	[ ] No	[ ] Unsure
Change in Bowel Habits Constipation/Diarrhea	[ ] Yes	[ ] No	[ ] Unsure
Blood in Stool	[ ] Yes	[ ] No	[ ] Unsure
Painful Urination	[ ] Yes	[ ] No	[ ] Unsure
Sense of Full Bladder	[ ] Yes	[ ] No	[ ] Unsure
Difficulty Urinating	[ ] Yes	[ ] No	[ ] Unsure
Blood in Urine	[ ] Yes	[ ] No	[ ] Unsure
Cough	[ ] Yes	[ ] No	[ ] Unsure
Wheezing	[ ] Yes	[ ] No	[ ] Unsure
Shortness of Breath	[ ] Yes	[ ] No	[ ] Unsure
Chest Pain	[ ] Yes	[ ] No	[ ] Unsure
Palpitations	[ ] Yes	[ ] No	[ ] Unsure
Leg/Feet Swelling	[ ] Yes	[ ] No	[ ] Unsure
Swelling/Redness in Joints	[ ] Yes	[ ] No	[ ] Unsure
Easy Bruising	[ ] Yes	[ ] No	[ ] Unsure
Seizures	[ ] Yes	[ ] No	[ ] Unsure
Dizziness	[ ] Yes	[ ] No	[ ] Unsure
Balance Problems	[ ] Yes	[ ] No	[ ] Unsure
New Headaches	[ ] Yes	[ ] No	[ ] Unsure
Depression	[ ] Yes	[ ] No	[ ] Unsure
Anxiety	[ ] Yes	[ ] No	[ ] Unsure
Itching/Rashes	[ ] Yes	[ ] No	[ ] Unsure
Sore/Bleeding Mole	[ ] Yes	[ ] No	[ ] Unsure
Other:			
Other:			