

Medical History

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Name:		Account #:	
Date:		Referred By:	

PRIMARY CARE PHYSICIAN:

CHIEF COMPLAINT

Why are you here today?			
Which side is involved?	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
What makes it better?			
What makes it worse?			
Your problem is the result of an: (Check all that apply)?			
<input type="checkbox"/> Accident	<input type="checkbox"/> Car Accident	<input type="checkbox"/> Work Accident	<input type="checkbox"/> Other

MEDICATIONS INCLUDING ALL VITAMINS, MINERALS & HERBS

	Medication	Dose/Frequency	How Long Taking?	Side Effects
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

ALLERGIES

Are you allergic to any of the following? (Check all that apply)						
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Keflex	<input type="checkbox"/> Latex	<input type="checkbox"/> Steroid injections
Other allergies:						
Serious side effects?						
For Women: Are you taking birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Week#:						

VITALS

Age:	Height:	Weight:
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Signature:	Date:
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Name:	Account #:
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SURGERIES / HOSPITALIZATIONS

#	Type of Surgery	Year	Complications?
1.			
2.			
3.			
4.			
5.			

Have you ever had general anesthesia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have any problems with anesthesia?	<input type="checkbox"/> Yes <input type="checkbox"/> No

REVIEW OF SYSTEMS

Check or circle all of the following diseases or medical problems that you have had at any time?

<input type="checkbox"/> High / Low Blood Pressure	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Anemia / Transfusions	<input type="checkbox"/> Epilepsy / Seizures / Fainting Spells
<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Heart Attack / Heart Bypass Surgery
<input type="checkbox"/> Blood Clots / Pulmonary Embolus	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Heart Murmur / Congenital defect
<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Mitral valve prolapse
<input type="checkbox"/> Hemophilia / Abnormal Bleeding	<input type="checkbox"/> Bladder Problems / Kidney Problems
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Bowel Problems
<input type="checkbox"/> Artificial bone or joints	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Bone infections	<input type="checkbox"/> Polio
<input type="checkbox"/> Eyes	<input type="checkbox"/> Low back pain / sciatica
<input type="checkbox"/> Ears / Nose / Throat	<input type="checkbox"/> Drug / Alcohol Abuse
<input type="checkbox"/> Stomach / Digestion	<input type="checkbox"/> Psychiatric Problems
<input type="checkbox"/> Thyroid	<input type="checkbox"/>
<input type="checkbox"/> Asthma / Trouble Breathing	<input type="checkbox"/>

Describe any additional medical information that you feel we need to know:

SOCIAL HISTORY

Occupation:	Employed By:
Work Status:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Restricted
<input type="checkbox"/> Disabled	<input type="checkbox"/> Retired <input type="checkbox"/> Work At Home <input type="checkbox"/> Student
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Children:	<input type="checkbox"/> No <input type="checkbox"/> Yes How Many? Do you live alone? <input type="checkbox"/> No <input type="checkbox"/> Yes
Exercise?	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rarely <input type="checkbox"/> Never
What type of exercise?	
Are you on a special diet?	<input type="checkbox"/> No <input type="checkbox"/> Yes Describe:
History of substance abuse?	<input type="checkbox"/> No <input type="checkbox"/> Yes Describe:
Smoke currently?	<input type="checkbox"/> No <input type="checkbox"/> Yes Packs per day for _____ years.
Quit smoking?	<input type="checkbox"/> This year <input type="checkbox"/> > 1 year <input type="checkbox"/> > 5 years <input type="checkbox"/> > 10 years
Previously smoked	Packs per day for _____ years.
Drink alcohol?	<input type="checkbox"/> Daily <input type="checkbox"/> 1-2x per week <input type="checkbox"/> Never <input type="checkbox"/> How much?