Medical History

Name: _____ Today's Date: _____

Date of Birth: _____

Why are you seeing the doctor today? _____

What is your level of pain? _____ Scale of : **0 ⟶ 10** **0 = No pain** **6 = Distress** **10 = Worse pain**

This problem is the result of a(n): **Check** all that apply

☐ Car Accident ☐ Work Accident ☐ Accident ☐ Legal action pending

☐ Other _____

This occurred during: **Check** all that apply

☐ Lifting ☐ Pulling ☐ Pushing ☐ Twisting ☐ Not Known

☐ Bending ☐ Squatting ☐ Hit by Object ☐ Falling

Medications	Dose	Frequency	Medications	Dose	Frequency

If you take any over the counter drugs (Aspirin, Tylenol, etc.) Please list above.

Medication Allergies ☐ None ☐ Yes (If yes, please list):

Are you allergic to latex? ☐ NO ☐ YES

Review of Systems

Are you currently having or have you had problems with your:

	Circle		Describe all Yes responses
Eyes	NO	YES	_____
Ears, Nose, Throat	NO	YES	_____
Lungs, Breathing	NO	YES	_____
Bowel Movement	NO	YES	_____
Bladder Problem	NO	YES	_____
Diabetes	NO	YES	_____
High Blood Pressure	NO	YES	_____
Bleeding Problems	NO	YES	_____
Blood Clots	NO	YES	_____
Balance Problems	NO	YES	_____
Numbness/tingling	NO	YES	_____
Blackout/fainting/Stroke	NO	YES	_____
Psychological Problems	NO	YES	_____
AIDS	NO	YES	_____
Cancer	NO	YES	_____
Arthritis	NO	YES	_____
TB	NO	YES	_____
Epilepsy	NO	YES	_____
Cardiac Problems (MI, angina, heart failure. . .)	NO	YES	_____
Kidney or Liver problems	NO	YES	_____
Other _____			

Form was reviewed by _____ MD/DO **Date _____**

(OVER)

Past Medical History

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia? ☐ No ☐ Yes
Have any problems with anesthesia? ☐ No ☐ Yes Describe: _____
Has any family member had a problem with anesthesia? ☐ No ☐ Yes Describe: _____

Family History

Do you have a family history of:

	NO	YES	RELATIONSHIP
Heart Disease	☐	☐	_____
Diabetes	☐	☐	_____
Cancer	☐	☐	_____
TB	☐	☐	_____
High Blood Pressure	☐	☐	_____
Stroke	☐	☐	_____

Other: _____

Social History

☐ Unemployed Last day worked? _____
☐ Work in the home ☐ Employed (occupation) _____ ☐ Student
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Children ☐ NO ☐ YES #_____
Do you live alone? ☐ NO ☐ YES
Do you feel you have adequate help in dealing with this illness or other problems? ☐ NO ☐ YES
If no, please explain _____
Exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
What type of exercise? _____
Are you on a special Diet? ☐ NO ☐ YES Describe: _____
Have you ever been abused? ☐ NO ☐ YES If Yes, ☐ Physically ☐ Emotionally ☐ Other_____
History of substance abuse? ☐ NO ☐ YES What: _____
Smoke currently? ☐ NO ☐ YES _____ Packs per day for _____ years
Quit smoking? ☐ This year ☐ > 1 year ☐ > 5 years ☐ > 10 years
Previously smoked _____ Packs per day for _____ years
Drink alcohol? ☐ Daily ☐ 1-2 x/week ☐ 1-2 x/month ☐ 1-2 x/year

Primary Care Doctor _____

PLEASE READ CAREFULLY AND SIGN

I have carefully read all questions and certify that the information I have given is correct and complete to the best of my knowledge.

Signature: _____ Date: _____
☐ **NO CHANGES** ☐ **CHANGES MADE FROM PREVIOUS MEDICAL HISTORY**
Signature: _____ Date: _____
☐ **NO CHANGES** ☐ **CHANGES MADE FROM PREVIOUS MEDICAL HISTORY**
Signature: _____ Date: _____
☐ **NO CHANGES** ☐ **CHANGES MADE FROM PREVIOUS MEDICAL HISTORY**
Signature: _____ Date: _____