PLEASE USE BLACK INK ONLY!

MEDICAL HISTORY

NAME:_____ DATE:_____ AGE:_____ SEX:_____ HEIGHT:_____ WEIGHT:_____
MARITAL STATUS(Circle One) Single Married Divorced Widowed RACE: (optional)_____
HOME/CITY/STATE:_____
OCCUPATION/SCHOOL:_____ CURRENT GRADE IN SCHOOL:_____
REFERRING PHYSICIAN:_____ PRIMARY CARE PHYSICIAN:_____

HABITS:

WHICH HAND DO YOU WRITE WITH? ❑ RIGHT ❑ LEFT
DO YOU USE TOBACCO? ❑ YES ❑ NO ❑ CHEW ❑ Packs per day_____ For how many years?_____
DO YOU DRINK ALCOHOL? ❑ YES ❑ NO How often?_____ How much?_____
WHO LIVES WITH YOU?_____
WHAT MEDICAL PROBLEMS RUN IN YOUR FAMILY? (1)_____(2)_____(3)_____
DO YOU HAVE ANY PERTINENT SOCIAL OR FAMILY HISTORY RELATIVE TO YOUR CLINICAL SITUATION?
❑ YES ❑ NO_____

	NAME OF DRUG	TYPE OF REACTION	DO YOU HAVE?	REACTION
ALLERGIES⇒	_____	_____	❑Dye/ Iodine Allergy	_____
	_____	_____	❑Latex Allergy	_____
❑ NO ALLERGIES	_____	_____	❑Nickel Allergy	_____
	_____	_____		

MY MEDICAL PROBLEMS (NOT MY FAMILY): ❑ NONE

YES	NO			YES	NO		
____	____	asthma	493.90	____	____	psychological problems	
____	____	copd/emphysema	496.0/492.8	____	____	"nervous breakdowns"	
____	____	high blood pressure	401.9	____	____	post-traumatic stress dis.	309.81
____	____	heart disease	429.9	____	____	depression	300.4
____	____	stroke	438.9	____	____	anxiety	300.00
____	____	TIA	435.9	____	____	seizures/convulsions	780.39
____	____	mitral valve prolapse	424.0	____	____	gallbladder disease (now)	575.9
____	____	heart attack	410.9	____	____	dental abscess (now)	522.5
____	____	pacemaker/defibrillator	V45.0/V45.2	____	____	glaucoma	365.9
____	____	atrial fibrillation	427.31	____	____	kidney disease	404.90
____	____	on Coumadin/ Plavix		____	____	kidney failure	
____	____	gout	274.0	____	____	kidney stones	592.0
____	____	diabetes	250.00	____	____	kidney/bladder infections	595.9
____	____	need insulin	250.10	____	____	dialysis (end stage renal dis)	586.
____	____	diverticulosis	562.11	____	____	degenerative muscle disease	729.9
____	____	irritable colon (IBS)	564.1	____	____	degenerative nerve disease	349.
____	____	crohn's disease	555.9	____	____	venereal disease (STD)	099.9
____	____	ulcerative colitis	556.9	____	____	hepatitis(A,B,C)	573.3
____	____	c. diff colitis	008.45	____	____	AIDS/HIV	042.
____	____	stomach ulcers	531.9	____	____	blood clot/DVT	444.9/453.40
____	____	GERD/reflux	530.81	____	____	bleeding disorders	286.9
____	____	hiatal hernia	553.3	____	____	hemophilia	286.9
____	____	gastritis	535.5	____	____	fibromyalgia	729.1
____	____	arthritis type:_____		____	____	multiple sclerosis	340.
____	____	lupus	710.0	____	____	thyroid disease	
____	____	ankylosing spondylitis	720.0	____	____	polio	780.57
____	____	obesity	278.00	____	____	sleep apnea	780.57
____	____	high cholesterol/lipids	272.0/272.4	____	____	chronic fatigue syndrome	780.71
____	____	parkinson's	332.0	____	____	history of Mrsa	41.12
____	____	history of alcohol/drug abuse (illegal or prescription) 305.0					
____	____	cancer: body part_____		when diagnosed:_____			

Other Medical Illnesses:_____

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PATIENT NAME:_____ **DATE OF OFFICE VISIT**_____

PREVIOUS OPERATIONS:

OPERATION	DATE	OPERATION	DATE
❑ Tonsillectomy	_____	❑ Joint Arthroscopy	_____
❑ Appendectomy	_____	❑ Joint Replacement	_____
❑ Gall Bladder	_____	which joint(s)_____	
❑ Fracture Repair	_____	_____	
❑ Breast Biopsy	_____	❑ Cancer Surgery_____	DATE:_____
❑ Benign ❑ Malignant		❑ Hysterectomy	
❑ Vascular Bypass (not heart)	_____	❑ Complete / Partial	_____
❑ Open heart/Stent/ Pacemaker	_____	❑ Cancer	_____
❑ Other:		❑ Cesearean Section	_____
Operation_____	Date_____	Operation_____	Date_____
Operation_____	Date_____	Operation_____	Date_____

OTHER SPECIALISTS THAT I AM CURRENTLY SEEING

PHYSICIAN_____ WHY_____
PHYSICIAN_____ WHY_____
PHYSICIAN_____ WHY_____

❑ **NO MEDICATIONS**

MEDICATIONS	HOW MUCH	HOW OFTEN	HOW LONG	MEDICATIONS	HOW MUCH	HOW OFTEN	HOW LONG
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

❑ **OR attach medications list**

REVIEW OF SYSTEMS

(PATIENT: CHECK ALL WITHIN THIS SECTION THAT YOU ARE CURRENTLY EXPERIENCING)

CONSTITUTIONAL
- ❑ Fever
- ❑ Sweats
- ❑ Chills
- ❑ Weight loss/Appetite Loss
- ❑ Fatigue

ENT
- ❑ Ringing in ears
- ❑ Sore Throat
- ❑ Hay Fever
- ❑ Difficulty Swallowing

CV
- ❑ Chest Pain
- ❑ Irregular Heart Beat
- ❑ High Blood Pressure
- ❑ Swollen Ankles

RESPIRATORY
- ❑ Shortness of breath
- ❑ Smoker
- ❑ Coughing up Blood
- ❑ Need or Use Oxygen

GI
- ❑ Poor appetite
- ❑ Nausea
- ❑ Vomiting
- ❑ Heartburn
- ❑ Constipation
- ❑ Diarrhea
- ❑ Blood in Stool

GU
- ❑ Frequent Urination
- ❑ Cannot Empty Bladder
- ❑ Difficulty Starting Urination
- ❑ Blood in Urine
- ❑ Smelly Urine
- ❑ Cannot Hold Urine

PSYCHIATRIC
- ❑ Trouble Sleeping
- ❑ Depression
- ❑ Nervous Breakdown
- ❑ Psychological problems
- ❑ Anxious

Other_____

MUSCULOSKELETAL
- ❑ Arthritis
- ❑ Deformity
- ❑ Limping
- ❑ Pain in Joints
- ❑ Stiffness in Joints
- ❑ Catching/Popping in Joints
- ❑ Use Crutches/ Walker
- ❑ Swelling

NEUROLOGICAL
- ❑ Headaches
- ❑ Dizziness
- ❑ Black-Out Spells
- ❑ Numbness-Tingling
- ❑ Weakness
- ❑ Loss of Balance
- ❑ Loss of Bowels/Bladder/Sex

HEMATOLOGICAL/LYMPHATIC
- ❑ Hemophilia
- ❑ Protein Deficiency
- ❑ Easy Bruising/Bleeding
- ❑ Frequent bloody nose

❑ **CHECK HERE IF NONE OF THE ABOVE APPLY**

Signature:_____ **Date/Time:**_____