

MEDICAL HISTORY

Patient Name _____ Date _____

Date of Birth _____

Primary Care Physician: _____ Referring MD: _____

Cardiologist: _____ Rheumatologist: _____

List any other specialist you see on a regular basis: _____

Preferred Pharmacy & Location: _____

Age: _____ Height: _____ Weight: _____ Are you Right or Left Handed? _____

What are you being seen here for today? _____

Which side? (Right or Left) _____ How long has this problem existed? _____

Place of employment: _____ Occupation: _____

Job Description: _____

Have YOU ever been diagnosed with the following? Please Check

- | | | |
|---|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Depression | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Alzheimer's | do you take insulin? Yes No | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Multiple Myeloma |
| <input type="checkbox"/> Anxiety/Panic Attacks | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD (Reflux) | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteomyelitis
(bone infection) |
| <input type="checkbox"/> Bleeding Ulcer | <input type="checkbox"/> Heart Attack,
when? _____ | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Blood Clots,
where? _____ | <input type="checkbox"/> Hemophilia/Bleeding | <input type="checkbox"/> Sarcoidosis |
| Cancer
Type? _____ | <input type="checkbox"/> Hepatitis A / B / C | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Stroke
TIA |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> High Cholesterol | |
| | <input type="checkbox"/> Age of Menopause (if applicable) _____ | |
| | <input type="checkbox"/> Have you ever had a bone density test? Yes No If yes, When: _____ Where: _____ | |
| | <input type="checkbox"/> Have you fallen in the past year and had an injury due to that fall? Yes No | |
| <input type="checkbox"/> Other Medical Problem _____ | | |

SURGERY HISTORY

Please list ALL surgeries you have had: _____ Date: _____

Have you ever had an adverse reaction to anesthesia? Yes No (local or general) Reaction: _____

Have you ever had a blood transfusion? Yes No When? _____ Why? _____

If yes, did you have any adverse reaction? Yes No If yes what was it: _____

Have you ever been tested for HIV/AIDS Yes No Results: _____

Do you have any Drug allergies? Yes No Reaction: _____

Drug: _____

Do you have a Latex allergy? Yes No

Please list ALL current medications and dosages (prescription, vitamins & herbal meds): None

Drug: _____ Dose: _____

Have you ever passed out from any type of injection? Yes No

Patient Name _____ Date _____

Date of Birth _____

FAMILY HISTORY

Has any BLOOD relative ever been diagnosed with following, please list relationship:

- Diabetes _____ Heart Attack _____ Cancer _____
- Hemophilia _____ Coronary Artery Disease _____ HIV/AIDS _____
- Rheumatoid Arthritis _____ Blood Clots _____
- None of the above

SOCIAL HISTORY

Do you smoke? Yes No Packs per day _____ for _____ years Type: Cigarettes Chewing tobacco Pipe

If tobacco use in the past, what year did you quit: _____

Do you currently use alcohol? Yes No Type: Beer Wine Liquor

How many drinks per week _____ If alcohol use in the past, what year did you quit: _____

Do you use illegal drugs? Yes No Type: _____ If illegal drug use in past, what year did you quit: _____

Marital Status: Single Married Divorced Widow Separated # of Children: _____

Are you pregnant at this time? Yes No Who lives at home with you? _____

Religion: _____

REVIEW OF SYSTEMS

Have you had any trouble with the following over the past 5 years

PLEASE CIRCLE YES or NO FOR EACH

GENERAL

Unexplained weight loss Yes No

EYES

Glasses Yes No

Contacts Yes No

BREATHING

Coughed up blood Yes No

STOMACH

Blood in stool Yes No

Heartburn Yes No

MUSCLE-BONE

Chronic back pain Yes No

Frequent joint stiffness Yes No

NEUROLOGICAL

Seizures Yes No

Fainting spells Yes No

SKIN

Rashes Yes No

EARS, NOSE, THROAT

Seasonal Allergies Yes No

Hearing Aids Yes No

HEART

Heart Murmur Yes No

Rheumatic fever Yes No

URINARY

Blood in urine Yes No

Can't hold urine Yes No

VASCULAR

Varicose Veins Yes No

Blood clots Yes No

MENTAL

Trouble sleeping Yes No

Change in Memory Yes No

Is this related to injury/accident? Yes No If yes, please give date and description of injury/accident:
Date: _____ Description: _____

Related to an Automobile accident? Yes No

Is this injury work related? Yes No

Have you contacted an Attorney? Yes No Attorney's name: _____

Is this for a second opinion? Yes No Who asked for this second opinion: _____

Have you seen another Physician for this problem? Yes No Who: _____

Were you seen in the Emergency Department at a Hospital? Yes No When: _____ Where: _____

Have you had X-Rays taken for this problem? Yes No When: _____ Where: _____