

For Office Use Only:	
Patient ID #:	_____
Height: _____	Weight: _____
BP: _____	Pulse: _____
Send today's chart note? <input type="checkbox"/> Yes / <input type="checkbox"/> No	

Medical History Form

Name: (Last) _____ (First) _____

Age: _____ Date of Birth: _____ Gender: Male / Female

Referring Physician (Name/City): _____

Primary Physician (Name/City): _____

Occupation: _____ Left / Right handed Work injury? Yes / No

History of Current Illness:

Chief Complaint (Why you sought care today): Left / Right _____

When did the problem start? _____ How did it start? _____

Made better or worse by: _____

The body part is: Painful Yes / No Weak Yes / No Stiff Yes / No Swollen Yes / No Numb Yes / No

Previous Images (X-rays, MRI, etc.): _____

Notes: _____

Current Medications: Please list medications. None

Name:	Dosage per day:	Reason:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name:	Dosage per day:	Reason:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: None Latex Please list all allergies and reaction:

Review of Symptoms: Please note any symptoms you've experienced within the past 6 months.

General:		Pulmonary:		Hematological:	
Weight loss (Unintentional)	Yes / No	Shortness of breath	Yes / No	Bleeding disorder	Yes / No
Weight gain	Yes / No	Wheezing / asthma	Yes / No	Blood clots	Yes / No
Chills	Yes / No	Coughing up blood	Yes / No	Psychiatric:	
Fever	Yes / No	Genitourinary:		Depression	Yes / No
Night sweats	Yes / No	Frequent urination	Yes / No	Bipolar	Yes / No
Skin:		Blood in urine	Yes / No	Schizophrenia	Yes / No
Rash	Yes / No	Kidney stone	Yes / No	ADD	Yes / No
Lesions	Yes / No	Urinary tract infection	Yes / No	Endocrine:	
HEENT:		Musculoskeletal:		Thyroid problems	Yes / No
Hay fever	Yes / No	Rheumatoid arthritis	Yes / No	Liver disease	Yes / No
Hoarseness	Yes / No	Osteoporosis	Yes / No	Neurological:	
Visual problems	Yes / No	Bone tumor	Yes / No	Loss of consciousness	Yes / No
Hearing problems	Yes / No	Gastrointestinal:		Headaches	Yes / No
Cardiovascular:		Indigestion	Yes / No	Dizziness	Yes / No
Chest pain	Yes / No	Nausea	Yes / No	Seizures	Yes / No
Palpitations	Yes / No	Vomiting	Yes / No	Lymphatic:	
Irregular heartbeat	Yes / No	Vomiting blood	Yes / No	Lymph node swelling	Yes / No
Rheumatic fever	Yes / No	Black stools	Yes / No	Node tenderness	Yes / No
Swollen ankles	Yes / No				

Name: (Last) _____ (First) _____ Patient ID#: _____

Medical History: Please indicate diseases or disorders you have now or experienced in the past.

Anemia	Yes / No	Dialysis	Yes / No	High cholesterol	Yes / No
Anxiety	Yes / No	Emphysema	Yes / No	Kidney stones	Yes / No
Arthritis	Yes / No	Fractures	Yes / No	Poor circulation	Yes / No
Asthma	Yes / No	Bone: _____		Pulmonary embolism	Yes / No
Bleeding disorder	Yes / No	Glaucoma	Yes / No	Reflux	Yes / No
Cancer	Yes / No	Gout	Yes / No	Renal failure	Yes / No
Type: _____		Heart attack	Yes / No	Sleep apnea	Yes / No
Chemotherapy	Yes / No	High blood pressure	Yes / No	Staph infection	Yes / No
Diabetes I	Yes / No	Hepatitis A	Yes / No	Stroke	Yes / No
(taking insulin)	Yes / No	Hepatitis B	Yes / No	Thyroid disease	Yes / No
Diabetes II	Yes / No	Hepatitis C	Yes / No	Tuberculosis	Yes / No
Are you taking insulin?	Yes / No	HIV	Yes / No	Ulcers	Yes / No
DVT (blood clot)	Yes / No			Other: _____	

Past Surgical History: Please indicate operations you have had.

Type:	Year:	Spine surgery	_____	Other Operations:	Year:
Heart bypass	_____	Hip surgery	_____	_____	_____
Pacemaker	_____	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	_____	_____
Heart valve	_____	Knee surgery	_____	_____	_____
Heart stent	_____	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	_____	_____
Cancer surgery	_____	Shoulder surgery	_____	_____	_____
Prostate surgery	_____	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	_____	_____

Family History: Please indicate whether anyone in your immediate family has ever experienced any of the following:

Heart disease	Yes / No	Arthritis	Yes / No
High blood pressure	Yes / No	Cancer	Yes / No
Bleeding problems	Yes / No	Osteoporosis	Yes / No
Diabetes	Yes / No	Other _____	

Social History:

- Marital status (circle one): Married / Divorced / Separated / Single / Widowed
- Live with (circle all that apply): Alone / Spouse / Children / Parents / Mother / Father / Guardian / Roommate / Partner

Habits/Risk Factors:

1. Do you use tobacco? Yes / No Type and quantity/day: _____ Start date: _____
2. Have you used tobacco in the past? Yes / No Start date: _____ Through: _____
3. Do you use recreational drugs? Yes / No Type and quantity/day: _____
4. Have you been treated for overdose or addiction? Yes / No Dates: _____
5. Do you drink alcohol? Yes / No Type and quantity/day: _____

Have you ever had a bone density scan? Yes / No When? _____

If over 65 years old: Have you ever had a pneumonia vaccine? Yes / No When? _____

If over 6 months old: Have you had a flu vaccine this year (Oct. 1st to Mar. 31st)? Yes / No Where? _____

Females: Are you pregnant? Yes / No Due Date: _____

Patient/Parent/Guardian Signature: _____ Date: _____

Health Provider Signature: _____ **Date:** _____