

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:

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

Form was reviewed by _____ MD/DO Date _____

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
TB	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
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:** _____