Medical History Form Date: _____________

PATIENT INFORMATION:

Name____
(First) (Middle) (Last)

Age: _______ **Date of Birth:** __________ **Gender:** M F

Right or Left Handed? _______________________

Occupation: ______________________________________

Working Status: (Circle one) Working Retired Disabled

REFERRING PHYSICIAN:

Name: ____
(First) (Last)

Phone: ____

PRIMARY CARE PHYSICIAN:

Name: ____
(First) (Last)

Phone: ____

Chief Complaint: (Example: Right hip pain) ____

Date of injury or onset of symptoms: ____/____/________

Describe your symptoms: (Example, a sharp pain when I walk.)____

____

How did injury happen? ____

____

Symptom Relief: (e.g. rest, heat/cold, therapy, medication) ____

Symptom Aggravation: (e.g. activity, movement) ____

Additional Symptoms: ____

Describe Treatment: ____

Have you had any diagnostic tests for this problem? Yes No **If yes, what & where?** ___________________________

Has a physician recommended that you have surgery for this problem? Yes No

Name of previous treating physician(s), if any? ____

PAST MEDICAL HISTORY:

____

____

____

PAST SURGICAL HISTORY: (Please list the surgical procedure, date of procedure and complications.)

____

____

____

Have you ever had problems with anesthesia? Yes No If yes, please describe: _______________________________

SOCIAL HISTORY:

Student: Yes No School? __________________________ Grade: ___________ Sport: ___________________________

Marital Status: Single Married Divorced Widowed Do you live alone? ____

Alcohol use: Never / Occasional / Daily / Heavy History of alcoholism? Yes No History of drug use? Yes No

FAMILY HISTORY:

____

____

____

Medical History Form Date: ______________

MEDICATIONS: (Prescription Nonprescription Herbal supplements Vitamins Other)

Medication Name	Dosage	Medication Name	Dosage

Are you taking: Low-dose aspirin? Yes No **Anti-coagulants?** Yes No **Corticosteroids?** Yes No

Have you taken at least two different anti-inflammatory medications for your condition? Yes No If yes, how long?_________

Have you ever had a Dexascan (bone density test)? Yes No

Have you ever had urinary loss of control? Yes No

Do you have a Living Will/Advance Directives? Yes No

Have you had any falls within the last year? Yes No

ALLERGIES: Please list type of allergy (medications, latex, metals, etc) and type of reaction you experience:

____

____

____

RISK FACTORS:

Tobacco Use: (Circle One) Never Smoked Former Smoker Current Smoker

Height: __________ **Weight:** ___________ **BP:** ____________

REVIEW of SYSTEMS: Have or do you ever experience any of the following signs or symptoms? If yes please describe.

	Yes	**No**	**Describe all "Yes" responses**
Eyes (e.g. blurred vision, double vision, loss of vision)	Yes	No	______________________
Ears, Nose, Throat (e.g. sore throat, earache, ringing)	Yes	No	______________________
Cardiovascular (e.g. chest pain, palpitations)	Yes	No	______________________
Respiratory (e.g. shortness of breath, cough, snore)	Yes	No	______________________
Gastrointestinal (e.g. ulcer, gastritis, GI bleed)	Yes	No	______________________
Genitourinary (e.g. burning, bleeding)	Yes	No	______________________
Musculoskeletal (e.g. joint, muscle, back or neck pain)	Yes	No	______________________
Skin (e.g. delayed healing, rash, acne, cellulitis)	Yes	No	______________________
Neurological (e.g. numbness, tingling, weakness)	Yes	No	______________________
Endocrine (e.g. weight gain/loss, excess thirst or urine)	Yes	No	______________________
Hematologic (e.g. bruising, bleeding, clotting disorder)	Yes	No	______________________
Allergic / Immunologic (e.g. rash, swelling, wheezing)	Yes	No	______________________

Comments or Clarification: ____

____

Patient/Guardian Statement:
To the best of my knowledge, the above information is accurate and complete.

________________________________ ___/___/_____
Patient Signature

________________________________ ___/___/______
Guardian Signature

____
Guardian/Authorized Representative Printed Name

Provider Statement:
I have reviewed the questionnaire with the patient.

Yes / No _______________________ __/___/____
Signed Date

Yes / No _______________________ __/___/____
Signed Date

Yes / No ______________________ __/___/____
Signed Date