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

**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