MEDICAL HISTORY FORM

Date _____

PATIENT INFORMATION

Name *(First) (Middle) (Last)* _____ ◯ Male ◯ Female

Age ____ **Date of Birth** _____

MEDICAL HISTORY

PAST MEDICAL HISTORY

PAST SURGICAL HISTORY *(Please list the surgical procedure, date of procedure and /or complications, if applicable)*

Have you ever had problems with anesthesia? ◯ Yes ◯ No

If yes, please describe:

Patient Name_____

SOCIAL HISTORY

Student? ◯ Yes ◯ No

School **Grade**

Sport

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Do you live alone? ◯ Yes ◯ No

Alcohol use ◯ Never ◯ Occasional ◯ Daily ◯ Heavy

History of alcoholism? ◯ Yes ◯ No

History of drug use? ◯ Yes ◯ No

FAMILY HISTORY

MEDICATIONS *(Prescription, nonprescription, herbal supplements, vitamins, other)*

Medication Name	Dosage	Medication Name	Dosage

Are you taking low-dose aspirin? ◯ Yes ◯ No

Are you taking anti-coagulants? ◯ Yes ◯ No

Are you taking corticosteroids? ◯ Yes ◯ No

Have you taken at least two different anti-inflammatory medications for your condition? ◯ Yes ◯ No

If yes, for how long?

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

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

RISK FACTORS

Tobacco use ◯ Never Smoked ◯ Former Smoker **Are you a current smoker?** ◯ Yes ◯ No

Height **Weight** **BP** \

Patient Name_____

REVIEW of SYSTEMS *(Have or do you ever experience any of the following signs or symptoms? (If yes, please describe)*

Sign/Symptom	Yes/No	Please 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	
Urinary (e.g. urinary loss of control)	◯ Yes No	

COMMENTS OR CLARIFICATION

Patient/Guardian Statement:

To the best of my knowledge, the above information is accurate and complete.

Patient Signature **Signed Date**

Guardian Signature ***(if patient is a minor)*** **Signed Date**

Guardian Printed Name

Provider Statement:

I have reviewed the questionnaire with the patient.

Any Changes?

◯ Yes
◯ No **Signed** **Date**

◯ Yes
◯ No **Signed** **Date**

◯ Yes
◯ No **Signed** **Date**