Name: DOB:
Chart: Age:
Date: Gender:

Patient Medical History

Name: ______________________ Date: ______________

Age: ________ Date of Birth: ____________ Height: ____________ Weight: ________

CHIEF COMPLAINT

Why are you seeing the doctor today? ______________________

Have you ever been treated for this problem before? ☐ Yes ☐ No

Date of Injury/ Onset of problem ______________________

Current problem is a result of: *Check all that apply:*

☐ Car Accident ☐ Work Accident ☐ Other *(specify)* ______________

MEDICAL HISTORY

Are you currently receiving treatment or have you received treatment in the past for any of the following conditions?

Yes	No	Condition
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Birth Defects
☐	☐	Bladder Problems
☐	☐	Bleeding or Bruising
☐	☐	Cancer Type ________
☐	☐	Diabetes
☐	☐	DVT / Blood Clots
☐	☐	Epilepsy
☐	☐	Gallbladder Problems
☐	☐	Gout
☐	☐	Heart Disease
☐	☐	Hepatitis
☐	☐	HIV / AIDS
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	Intestinal/ Bowel Problems
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Lung Problems
☐	☐	Phlebitis
☐	☐	MRSA / Staph Infection
☐	☐	Osteoporosis
☐	☐	Peripheral Vascular Disease
☐	☐	Polio
☐	☐	Psychological problems
☐	☐	Pulmonary Embolism
☐	☐	Rheumatic Fever
☐	☐	Sexually Transmitted Disease
☐	☐	Stroke / TIA
☐	☐	Tuberculosis
☐	☐	Thyroid Problems
☐	☐	Ulcer Type ________

Are there any other medical problems we should know about? ______________________

Are you right or left-hand dominant? ☐ Right ☐ Left

Are you or could you be pregnant? ☐ Yes ☐ No

Do you exercise or participate in sports regularly? ☐ Yes ☐ No

Type and Frequency: ______________________

MEDICATIONS

Please list all medications you take with or without a prescription (use extra paper if needed)

Medication Name	Dosage / # per day	Reason for taking

ALLERGIES

Please describe any current or past allergic reactions

Allergy to (drug)	Reaction (itching, cough, hives, etc)	How was / is the reaction treated?

☐ I DO NOT have any allergies

SURGERIES AND HOSPITALIZATIONS

☐ Arthroscopy ______________ Year ______ Physician ______________ Complication? ______

☐ Joint replacement ______________ Year ______ Physician ______________ Complication? ______

☐ Bone or joint reconstruction ______________ Year ______ Physician ______________ Complication? ______

☐ Spine surgery ______________ Year ______ Physician ______________ Complication? ______

☐ Other general surgery ______________ Year ______ Physician ______________ Complication? ______

______________ Year ______ Physician ______________ Complication? ______

☐ Other hospitalizations ______________ Year ______ Physician ______________ Complication? ______

☐ I HAVE NOT HAD any surgeries or hospitalizations

Name: DOB:
Chart: Age:
Date: Gender:

FAMILY HISTORY

Have your mother, father, grandparents, brothers or sisters been treated in the past or are they currently receiving treatment for any of the following conditions?

Yes	No		Yes	No		Yes	No		
☐	☐	Alzheimer's	☐	☐	Diabetes	☐	☐	Osteoporosis	Other_____________
☐	☐	Arthritis	☐	☐	Gout	☐	☐	Stroke	_____________
☐	☐	Cancer	☐	☐	Heart Disease	☐	☐	Sudden Death	_____________

SOCIAL HISTORY

What type of work do you do? (describe your duties) ________________________ How long have you been doing it? __________

Do you drink alcoholic beverages? ☐ Yes ☐ No Amount and frequency: ______________________________

Do you use recreational drugs? ☐ Yes ☐ No Type and frequency: ______________________________

What activities (sports/hobbies) do you enjoy? ____

SMOKING STATUS

☐ Current everyday smoker Start date: _________
☐ Current someday smoker Start date: _________
☐ Smoker, current status unknown Start date: _________
☐ Never smoker
☐ Former smoker Start date: _________ Quit date: _________
☐ Unknown if ever smoked

REVIEW OF SYSTEMS *Please check the following symptoms you have experienced on a regular basis:*

GENERAL
☐ Fever
☐ Weight change
☐ Hormonal problems
☐ Other ______________
☐ NONE

CARDIOVASCULAR
☐ Chest pain
☐ Palpitations
☐ Fluid/ Swelling in extremities
☐ Other ______________
☐ NONE

KIDNEY/ BLADDER
☐ Painful urination
☐ Frequent urination
☐ Incontinence
☐ Other ______________
☐ NONE

EYES
☐ Glasses/ Contacts
☐ Cataracts
☐ Glaucoma
☐ Other ________
☐ NONE

RESPIRATORY
☐ Shortness of breath
☐ Sleep apnea
☐ Wheezing
☐ Other ______________
☐ NONE

EARS, NOSE, THROAT
☐ Difficulty swallowing
☐ Ear pain
☐ Seasonal allergies
☐ Hard of hearing
☐ Other ______________
☐ NONE

GASTROINTESTINAL
☐ Heartburn
☐ Diarrhea/ Constipation
☐ Abdominal pain
☐ Nausea/ vomiting
☐ Other ______________
☐ NONE

SKIN
☐ Rashes
☐ Lumps
☐ Other ________
☐ NONE

HEMATOLOGIC/ LYMPHATIC
☐ Anemia
☐ Blood problems
☐ Clotting disorder
☐ Lymph Problems
☐ Other ______________
☐ NONE

NEUROLOGICAL
☐ Headaches
☐ Numbness
☐ Tingling
☐ Seizures
☐ Weakness
☐ Other ____________
☐ NONE

PSYCHOLOGICAL
☐ Anxiety
☐ Depression
☐ Mood swings
☐ Other ________
☐ NONE

Pain Scale - If you are having pain, please rate the intensity of your pain on a scale of 1 -10.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9

Patient Name: ____ **Date:** ____________

Patient Signature: ____________________________________ **Date:** ____________