

Medical History

Name _____ Phone _____ Birthdate ____ / ____ / ____ Age ____ Sex M F
Who requested you see our physicians? _____ City _____
Your Internist or Family Physician: _____ City _____

What is your major problem or complaint? _____

When did your problem start? _____

Was there a specific injury? ____ If so, what happened? _____

Do you consider it work related? ____ How? _____

What treatment have you received for this problem? _____

Have you seen other doctors for this problem? ____ Who? _____

Past Medical History (check all present):

- | | | | | |
|---|---|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis/gout | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cancer | <input type="checkbox"/> Serious Infection | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Hereditary defects |
| <input type="checkbox"/> Hepatitis/ liver disease | <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Psychiatric illness | <input type="checkbox"/> Ulcer/stomach diff. | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> COPD/asthma | <input type="checkbox"/> Head injury . | <input type="checkbox"/> Anemia |
- Other: _____
Explain: _____

Previous surgeries (include year): _____

Systems review (check all present):

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Rash/unusual mole | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Cold extremities | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Tremors | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Visual change |
| <input type="checkbox"/> Weight change | <input type="checkbox"/> Bladder difficulties | <input type="checkbox"/> Back pain | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Numbness/tingling |
- Other: _____
Explain: _____

Medications you are taking (include dose, over the counter drugs and vitamins): _____

Allergies: _____

Diseases that run in the family (include deceased family members): _____

Do you smoke now? ____ If so, packs/day: ____ Have you in the past? ____ When did you quit? ____

Do you drink alcohol excessively? ____ Do you use drugs? ____ Have you been treated for substance abuse? ____

Marital Status ____ Number of children ____ Do you have a health care directive or power of attorney? ____

Occupation: _____ Height: _____ Weight: _____