Medical History

Name: ______________________ **Today's Date:** ______________

SS#: ______________________ **Date of Birth:** ______________

Why are you seeing the doctor today? ______________________________________

What is your level of pain? ________ Scale of : **0 ⟶ 10** **0 = No pain** **6 = Distress** **10 = Worse pain**

This problem is the result of a(n): **Check** all that apply

☐ Car Accident ☐ Work Accident ☐ Accident ☐ Legal action pending

☐ Other ______________

This occurred during: **Check** all that apply

☐ Lifting ☐ Pulling ☐ Pushing ☐ Twisting ☐ Not Known

☐ Bending ☐ Squatting ☐ Hit by Object ☐ Falling

Medications	Dose	Frequency	Medications	Dose	Frequency

If you take any over the counter drugs (Aspirin, Tylenol, etc.) Please list above.

Medication Allergies ☐ **None** ☐ **Yes** **(If yes, please list):**

Are you allergic to latex? ☐ NO ☐ YES

Review of Systems

Are you currently having or have you had problems with your:

	Circle		Describe all Yes responses
Eyes	NO	YES	____________
Ears, Nose, Throat	NO	YES	____________
Lungs, Breathing	NO	YES	____________
Bowel Movement	NO	YES	____________
Bladder Problem	NO	YES	____________
Diabetes	NO	YES	____________
High Blood Pressure	NO	YES	____________
Bleeding Problems	NO	YES	____________
Blood Clots	NO	YES	____________
Balance Problems	NO	YES	____________
Numbness/tingling	NO	YES	____________
Blackout/fainting/Stroke	NO	YES	____________
Psychological Problems	NO	YES	____________
AIDS	NO	YES	____________
Cancer	NO	YES	____________
Arthritis	NO	YES	____________
TB	NO	YES	____________
Epilepsy	NO	YES	____________
Cardiac Problems (MI, angina, heart failure. . .)	NO	YES	____________
Kidney or Liver problems	NO	YES	____________

Other ______________________________________

Form was reviewed by ______________ **MD/DO** **Date** ____________

(OVER)

Past Medical History

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia? ☐ No ☐ Yes
Have any problems with anesthesia? ☐ No ☐ Yes Describe: ______________
Has any family member had a problem with anesthesia? ☐ No ☐Yes Describe: ______________

Family History

Do you have a family history of:

	NO	YES	RELATIONSHIP
Heart Disease	☐	☐	______________
Diabetes	☐	☐	______________
Cancer	☐	☐	______________
TB	☐	☐	______________
High Blood Pressure	☐	☐	______________
Stroke	☐	☐	______________

Other: ______________

Social History

☐ Unemployed Last day worked? ______________
☐ Work in the home ☐ Employed (occupation) ______________ ☐ Student
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Children ☐ NO ☐ YES #________
Do you live alone? ☐ NO ☐ YES
Do you feel you have adequate help in dealing with this illness or other problems? ☐ NO ☐ YES
If no, please explain ______________
Exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
What type of exercise? ______________
Are you on a special Diet? ☐ NO ☐ YES Describe: ______________
Have you ever been abused? ☐ NO ☐ YES If Yes, ☐ Physically ☐ Emotionally ☐ Other______________
History of substance abuse? ☐ NO ☐ YES What: ______________
Smoke currently? ☐ NO ☐ YES _____ Packs per day for ______ years
Quit smoking? ☐ This year ☐ > 1 year ☐ > 5 years ☐ > 10 years
Previously smoked _____ Packs per day for ______ years
Drink alcohol? ☐ Daily ☐ 1-2 x/week ☐ 1-2 x/month ☐ 1-2 x/year

Primary Care Doctor ______________

PLEASE READ CAREFULLY AND SIGN

I have carefully read all questions and certify that the information I have given is correct and complete to the best of my knowledge.

Signature: ______________ **Date:** ______________

☐ **NO CHANGES** ☐ **CHANGES MADE FROM PREVIOUS MEDICAL HISTORY**

Signature: ______________ **Date:** ______________

☐ **NO CHANGES** ☐ **CHANGES MADE FROM PREVIOUS MEDICAL HISTORY**

Signature: ______________ **Date:** ______________

☐ **NO CHANGES** ☐ **CHANGES MADE FROM PREVIOUS MEDICAL HISTORY**

Signature: ______________ **Date:** ______________