

# MEDICAL HISTORY FORM

NAME: \_\_\_\_\_

AGE: \_\_\_\_\_

PREFERRED NAME: \_\_\_\_\_

RELIGION: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ DOB: \_\_\_\_\_ PHARMACY/PHONE#: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

ALLERGIES (Drug/Food/Latex/Metal): \_\_\_\_\_

CURRENT MEDICATIONS/DOSAGES: \_\_\_\_\_

## MEDICAL HISTORY

### Have you had any of these problems?:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV                                | <input type="checkbox"/> Depression              | <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> Reflux                   |
| <input type="checkbox"/> Asthma                                  | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney Stones                 | <input type="checkbox"/> Renal Failure/Dialysis   |
| <input type="checkbox"/> Bleeding Problems                       | <input type="checkbox"/> Dislocated Joint: _____ | <input type="checkbox"/> Liver Disease                 | <input type="checkbox"/> Rheumatoid Arthritis     |
| <input type="checkbox"/> Blood Clots (DVT)                       | <input type="checkbox"/> Fibromyalgia            | <input type="checkbox"/> Migraine Headaches            | <input type="checkbox"/> Seizures                 |
| <input type="checkbox"/> Blood Clot in Lung (Pulmonary Embolism) | <input type="checkbox"/> Fractured Bone: _____   | <input type="checkbox"/> Mitral Valve Prolapse         | <input type="checkbox"/> Scoliosis (Curved Spine) |
| <input type="checkbox"/> Bone Infection                          | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Neck Injury                   | <input type="checkbox"/> Stomach Problems         |
| <input type="checkbox"/> Cancer: _____                           | <input type="checkbox"/> Gout                    | <input type="checkbox"/> Osteoarthritis                | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Carpal Tunnel Syndrome                  | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Osteoporosis                  | <input type="checkbox"/> Thyroid Problems         |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease   | <input type="checkbox"/> Hepatitis: _____        | <input type="checkbox"/> Paralysis-partial or complete | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Cushing's Syndrome                      | <input type="checkbox"/> Herniated Disc          | <input type="checkbox"/> Parkinson's Disease           | <input type="checkbox"/> Ulcer Disease            |
| <input type="checkbox"/> Dental Cavities/Periodontal Disease     | <input type="checkbox"/> Hiatal Hernia           | <input type="checkbox"/> Peripheral Vascular Disease   | <input type="checkbox"/> Rheumatic Fever          |
|  |  |  | <input type="checkbox"/> Other: _____             |

## SURGICAL HISTORY

### Have you ever had an operation to the following areas?:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Abdomen _____   | <input type="checkbox"/> Extremity _____    | <input type="checkbox"/> Kidney _____             | <input type="checkbox"/> Pacemaker Insertion _____     |
| <input type="checkbox"/> Back/Neck _____ | <input type="checkbox"/> Fracture _____     | <input type="checkbox"/> Lung _____               | <input type="checkbox"/> Defibrillator Insertion _____ |
| <input type="checkbox"/> Cancer _____    | <input type="checkbox"/> Hysterectomy _____ | <input type="checkbox"/> Open Heart Surgery _____ | <input type="checkbox"/> Stent Insertion _____         |
|  |   |   | <input type="checkbox"/> Other _____                   |

## FAMILY HISTORY

### DO YOU HAVE A FAMILY HISTORY OF:

### If YES, who?:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Heart Disease _____       | <input type="checkbox"/> Problems with anesthesia _____ |
| <input type="checkbox"/> Cancer _____    | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Other _____                    |
| <input type="checkbox"/> Diabetes _____  | <input type="checkbox"/> Osteoporosis _____        |   |

Name

Age

Alive / Deceased

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Sister: \_\_\_\_\_

Brother: \_\_\_\_\_

## SOCIAL HISTORY

### DO YOU:

- |                                    |                    |   |
|------------------------------------|--------------------|---|
| Consume Alcoholic Beverages: _____ | YES _____ NO _____ | If yes, how much/often: _____             |
| Consume Tobacco Products: _____    | YES _____ NO _____ | If yes, how much/often: _____             |
| Are you a past smoker: _____       | YES _____ NO _____ | If yes, how long ago did you quit?: _____ |

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Entered by: \_\_\_\_\_ Date: \_\_\_\_\_ Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_