Medical History Information Sheet

Patient Name: ______________________ **Sex:** ☐ Male ☐ Female

DOB: __________ **Age:** ________ **Height:** __________ **Weight:** __________

Visit Information

Primary Care Physician: ____________________ Referring Physician: ____________________

Reason for Visit: ______________________________ Date of Injury: ___/___/___

Pain Quality: ☐ Dull / Ache ☐ Sharp / Stabbing ☐ Throbbing ☐ Shooting ☐ Pressure ☐ Electric ☐ Click / Pop

Severity: None ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ Intolerable ◯ Duration of Pain: __________ Location of Pain: __________

Pain Aggravated By:

☐ Standing ☐ Walking ☐ Lying ☐ Stooping
☐ Sleeping ☐ Working ☐ Stairs ☐ Bending
☐ Sitting ☐ Driving ☐ Lifting ☐ Turning

Treatments Attempted: ☐ **NONE** ☐ **Other** __________

☐ Pain Medications ☐ Anti-Inflammatory ☐ Rest
☐ Wheelchair ☐ Physical Therapy ☐ Ice
☐ Injections/ESI ☐ Chiropractic Care ☐ Surgery

Past Medical History

Please note all health issues you are currently experiencing

☐ Heart Disease ☐ Lung Disease ☐ Kidney Disease ☐ Liver Disease ☐ Chronic Headaches
☐ Malignant Hyperthermia ☐ Pulmonary Embolism ☐ Diabetes ☐ Hepatitis ☐ Thyroid Problems
☐ Hypertension ☐ Asthma ☐ Rheumatoid Arthritis ☐ Jaundice ☐ HIV/AIDS
☐ DVT (Blood Clots) ☐ Depression ☐ Osteoarthritis ☐ Stomach Ulcers ☐ Other __________
☐ High Cholesterol ☐ Recurrent Infections ☐ Gout ☐ Cancer __________

Surgical History ■ NONE

Please list all previous surgeries and approximate dates of surgery

Surgery:	Date:	Surgery:	Date:
__________	___/___/___	__________	___/___/___
__________	___/___/___	__________	___/___/___
__________	___/___/___	__________	___/___/___
__________	___/___/___	__________	___/___/___
__________	___/___/___	__________	___/___/___

Medications ■ NONE

Please list all current medications including over-the-counter medications, vitamins, herbal supplements, and prescribed drugs

Medication:	Dose:	Medication:	Dose:
__________	______	__________	______
__________	______	__________	______
__________	______	__________	______
__________	______	__________	______
__________	______	__________	______

Allergies ■ NONE KNOWN

Known Drug Allergies:

☐ Latex ☐ Shellfish ☐ Diagnostic Dyes ☐ Metal ☐ Antibiotics ☐ Other __________

Social History

Occupation Current: ____________________ ☐ Disabled Reason for Disability: __________

Past: ____________________ ☐ Retired ____________________

Do you currently live alone? ☐ No ☐ Yes - Relationship: ____________________

Have you ever been a smoker? ☐ No ☐ Yes - ________ Packs / Day Quit: ________ Months Ago ________ Years ago

Do you drink alcohol? ☐ No ☐ Yes - ☐ Social ☐ Moderate - 1-2 drinks/day ☐ Frequent - 3 or more drinks/day

Any recreational drug use? ☐ No ☐ Yes - Please List: ____________________

☐ ☐

Family History

Please note health issues affecting mother, father, sister or brother and indicate which family member is affected

☐ Blood Clots ________	☐ Aneurysm ________	☐ Arthritis ________	☐ Other ________
☐ Heart Disease ________	☐ Stroke/TIA ________	☐ Hip Disorders ________	☐ Cancer - Type: ________
☐ Respiratory Disorders ________	☐ Diabetes ________	☐ Autoimmune ________	Family Member: ________
☐ High Blood Pressure ________	☐ Neurological Disorders ________	☐ Malignant Hyperthermia ________	

Review of Systems

Please check all that apply

Constitutional	☐ Weight Loss	☐ Weight Gain	☐ Fatigue	☐ Decreased Appetite
	☐ Chills	☐ Fever	☐ Night Sweats	
Eyes	☐ Blurred Vision	☐ Vision Loss	☐ Eye Pain	☐ Eye Redness
	☐ Double Vision	☐ Glasses	☐ Contacts	
Ear, Nose & Throat	☐ Hearing Loss	☐ Ringing in the Ear	☐ Sinus Pressure	☐ Sore Throat
	☐ Swollen Glands			
Cardiovascular	☐ Chest Pain	☐ Palpitations	☐ Hand / Foot Swelling	☐ Leg Pain w/ Walking
Respiratory	☐ Cough	☐ Wheezing	☐ Snoring	☐ Shortness of Breath
Gastrointestinal	☐ Nausea / Vomiting	☐ Diarrhea	☐ Constipation	☐ Abdominal Pain
	☐ Stool Incontinence			
Genitourinary	☐ Burning w/ Urination	☐ Urinary Frequency	☐ Urinary Urgency	☐ Blood in Urine
	☐ Urinary Incontinence			
Musculoskeletal	☐ Bone Pain	☐ Muscle Pain	☐ Joint Pain	☐ Joint Swelling
	☐ Arm Pain	☐ Arm Weakness	☐ Leg Pain	☐ Leg Weakness
Integumentary	☐ Skin Rash	☐ Itching	☐ Hives	
Neurologic	☐ Headaches	☐ Weakness	☐ Numbness	☐ Memory Loss
	☐ Tingling	☐ Balance Difficulty	☐ Seizures	☐ Poor Arm / Leg Coordination
Psychological	☐ Depression	☐ Anxiety	☐ Irritability	☐ Sleep Disturbance
	☐ Suicidal Ideation			
Endocrine	☐ Heat Intolerance	☐ Excessive Thirst	☐ Excessive Hunger	
Hematologic	☐ Easy Bleeding	☐ Easy Bruising	☐ Bleeding Disorders	
Immunological	☐ Seasonal Allergies	☐ Recurrent Infections		

Other important health information: ____________________

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Signature

Patient Signature ____________________ **Date** ________