DATE: ____________________

MEDICAL HISTORY

For Office Use Only
BP: ________ P: ________
Wt: ________ Ht: ________

NAME: ______________________________ **BIRTHDATE:** ____________________

Current Review:
Height: __________ feet ___________ inches Weight: ____________lbs.

List all allergies you have
(Indicate **NA** if NO allergies)

____
____
____
____
____

Current medications
(include vitamins, herbs and over the counter medications):

Drug	Dosage	Prescribed by

If more medications, please attach a list

Hand Dominance: ❑ Right Handed ❑ Left Handed ❑Ambidextrous

If you are 65 or older, have you had a bone density test? ❑ **Yes when:** ____________________ ❑ **No**

Social History:
Do you use tobacco products? ❑Yes type: ________________❑No
If no, have you ever use tobacco products? ❑Yes ❑No
If yes, type: ________________ when did you quit? ______________
Do you drink alcoholic beverages? ❑Yes ❑No
Type: ________________ Amount/Frequency: ________________

Have you ever used recreational drugs? ❑Yes ❑No
If yes, type(s) used: ______________________________
Are you at risk for HIV (AIDS)? ❑Yes ❑No
(for example: blood transfusion(s), drug use, unprotected sexual contact)
Please explain: ______________________________
____

Past History: Please check any that you have or have had in the past
❑ Heart Problems ❑ Thyroid Disease ❑ Diabetes ❑ Hypertension

Surgical History: List all previous operations and dates:
(1) ______________________________
(2) ______________________________
(3) ______________________________
(4) ______________________________

Surgical Risk Factors:
Have you been treated for blood clots? ❑Yes ❑No
If yes, where was the blood clot located: ❑Leg(s) ❑Lung(s) what side was the blood clot on? ❑Right ❑Left

Check the following concerning surgery problems that apply to you or relatives during or after surgery:
❑ bleeding disorder ❑ No problems ❑ Yes (myself) ❑ Yes (relative)
❑ anesthesia ❑ No problems ❑ Yes (myself) ❑ Yes (relative)

Did any of your relatives die during or soon after surgery? ❑Yes ❑No
If yes, please explain:______________________________

Family History:
Please list any serious medical problems that your blood relatives have experienced

Relative______________________________ ❑living ❑deceased
Problem ______________________________
Relative______________________________ ❑living ❑deceased
Problem ______________________________
Relative______________________________ ❑living ❑deceased
Problem ______________________________

Systems Review: **CHECK ANY OF THE FOLLOWING SYMPTOMS OR CONDITIONS YOU HAVE HAD OR NOW HAVE**

Bleeding Problems

- ❐ bleeding disorder
- ❐ anemia
- ❐ bleeding tendencies

Eye & Vision

- ❐ eye pain or redness
- ❐ loss, change or double vision
- ❐ excessive watering

Ears & Hearing

- ❐ loss of hearing or buzzing
- ❐ chronic ear infections
- ❐ excessive drainage

Nose & Throat

- ❐ frequent nosebleeds
- ❐ excessive sneezing
- ❐ hoarseness
- ❐ blocked nasal passages
- ❐ frequent drainage or large quantity of sputum
- ❐ difficulty swallowing

Respiratory

- ❐ tuberculosis
- ❐ emphysema
- ❐ pneumonia
- ❐ asthma
- ❐ pain with breathing
- ❐ wheezing
- ❐ excessive cough
- ❐ bloody sputum
- ❐ becomes short of breath easily even rest periods

Cardiovascular

- ❐ heart attack
- ❐ anemia
- ❐ heart murmur
- ❐ stroke
- ❐ rheumatic fever
- ❐ abnormal or fast heartbeat
- ❐ calf cramps when walking
- ❐ abnormal low blood pressure
- ❐ fingers or toes are always cold
- ❐ phlebitis
- ❐ chest pain
- ❐ varicose veins
- ❐ frequent swelling in ankles and/or feet

Gastrointestinal

- ❐ liver problem
- ❐ ulcer
- ❐ pancreatitis
- ❐ colitis
- ❐ jaundice
- ❐ bloody vomitus
- ❐ gallbladder trouble
- ❐ frequent nausea or vomiting
- ❐ lack or loss of appetite
- ❐ frequent or severe constipation
- ❐ recurring diarrhea
- ❐ stomach or abdominal pain
- ❐ digestion difficulties or frequent belching
- ❐ persistent anal itch
- ❐ hemorrhoids or piles
- ❐ blood in your stools

Gentile-Urinary

- ❐ frequent urination
- ❐ painful urination
- ❐ excessive urine
- ❐ difficulty with urination
- ❐ abnormality of testicles
- ❐ stricture
- ❐ abnormal or painful menses
- ❐ prostatitis
- ❐ changes in breast or nipples (swelling, pain, lumps, discharge, irritation, infection)
- ❐ infertile
- ❐ chronic urgency
- ❐ flank pain
- ❐ penile pain
- ❐ scrotal swelling
- ❐ vaginal pain
- ❐ tubal infections
- ❐ uterine fibroids or tumors

Neurological

- ❐ tension headaches
- ❐ migraine headaches
- ❐ epilepsy or seizures
- ❐ tropical disease
- ❐ severe or frequent headaches
- ❐ unusual head or neck tension
- ❐ shaking or twitching spells
- ❐ paralysis of the limbs
- ❐ frequent or constant numbness
- ❐ polio
- ❐ convulsions
- ❐ severe memory lapses
- ❐ blackouts
- ❐ dizziness

Psychological (Emotional)

- ❐ emotional illness
- ❐ nervous breakdown
- ❐ insomnia
- ❐ excessive worry
- ❐ hysterical/panic attacks
- ❐ recurrent feelings of loneliness
- ❐ feelings of worthlessness
- ❐ constant unhappiness
- ❐ recurrent feelings of hopelessness
- ❐ severe tension
- ❐ frequent crying
- ❐ frequent nightmares

Musculoskeletal

- ❐ dislocated joint
- ❐ torn cartilage
- ❐ torn ligament
- ❐ torn muscle(s)
- ❐ torn tendon(s)
- ❐ bone infection
- ❐ joint swelling
- ❐ arthritis
- ❐ tendinitis
- ❐ bursitis
- ❐ severely sprained joint
- ❐ joint laxity
- ❐ joint pain
- ❐ gout
- ❐ brittle bones
- ❐ soft bones
- ❐ bone cyst
- ❐ loss of joint motion
- ❐ painful bone spurs
- ❐ curved spine
- ❐ osteoporosis
- ❐ fractures
- ❐ ruptured disc or sciatica
- ❐ neck or back pain
- ❐ amputation

Other medical condition not already listed: ____

____

Patient Signature: ______________________________________ **Date:** ________________