

# PATIENT MEDICAL HISTORY

Patient Name: X

Chart Number: \_\_\_\_\_

## MEDICAL ILLNESSES

Do you have presently or have you ever been diagnosed with any of these illnesses?

- |   |   |  |              |
|---|---|--|--------------|
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Liver Disease  | <input type="checkbox"/> Stomach Ulcers      | Others _____ |
| <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Blood Clots in Legs | _____        |
| <input checked="" type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Cancer              | _____        |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Depression          | _____        |

## SURGICAL HISTORY

Have you ever had any of the following surgeries?

- |   |   |  |              |
|---|---|--|--------------|
| <input type="checkbox"/> Heart Bypass         | <input type="checkbox"/> Hysterectomy     | <input type="checkbox"/> Arthroscopy       | Others _____ |
| <input type="checkbox"/> Appendectomy         | <input type="checkbox"/> Tonsillectomy    | <input type="checkbox"/> Joint Replacement | _____        |
| <input type="checkbox"/> Gall Bladder Removal | <input type="checkbox"/> Fracture Surgery | <input type="checkbox"/> Spine Surgery     | _____        |

## FAMILY HISTORY

Do any of the following medical problems run in your family?

- |  |  |  |              |
|--|--|--|--------------|
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Bleeding Problems | Others _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis      | _____        |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Depression          |  | _____        |

## MEDICATIONS

LIST ATTACHED

Please list any medications that you take, including how much and how often if possible. Include over the counter medications and any supplements (glucosamine, ginkgo baloba, etc) You may attach a list if you have one!


## ALLERGIES

Are you allergic to any medications?

- |                                     |                                   |                                       |
|-------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Aspirin  | <input type="checkbox"/> Others _____ |
| <input type="checkbox"/> Codeine    | <input type="checkbox"/> Novocain | _____                                 |

## SOCIAL HISTORY

Please complete the following information

- |  |   |
|--|---|
| Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No         | Occupation _____  |
| Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated |
|  | <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed                                  |

## REVIEW OF SYSTEMS

Do you presently have any of the following problems

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Numbness        | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Watery Eyes         | <input type="checkbox"/> Indigestion            | <input type="checkbox"/> Weakness        | <input type="checkbox"/> Constipation      |
| <input type="checkbox"/> Blurry Vision       | <input type="checkbox"/> Joint Pain             | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Skin Ulcers       |
| <input type="checkbox"/> Double Vision       | <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Problems Sleeping |
| <input type="checkbox"/> Cough               | <input type="checkbox"/> Burning with urination | <input type="checkbox"/> Rashes          | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Wheezing            | <input type="checkbox"/> Incontinence           | <input type="checkbox"/> Leg Swelling    | <input type="checkbox"/> Joint Swelling    |
| <input type="checkbox"/> Shortness of Breath |   |  |  |

Please Turn Over

**VITAL SIGNS**

Pulse \_\_\_\_\_ Respiration \_\_\_\_\_ Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Height \_\_\_\_\_  
 Weight \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS**

What problem(s) brought you into the Doctor today? Check all that apply, write a R, L, or B (for right, left or both) beside the body part if there is more than one area

- Neck     Back     Shoulder     Arm     Shoulder     Elbow     Hand  
 Hip     Knee     Ankle     Foot    Other \_\_\_\_\_  
 Right     Left     Both     Right worse than left     Left worse than right     Both same

When did it start? \_\_\_\_/\_\_\_\_/\_\_\_\_     Not sure    \_\_\_\_     Mos     Wks     Days Before today

Did the problem start with a injury or accident?     Yes     No    Did it occur at work?     Yes     No

Describe the pain     Sharp     Other     Intermittent     Other  
 Dull    \_\_\_\_\_     Constant    \_\_\_\_\_  
 Check all that apply     Burning    \_\_\_\_\_     One area  
 Multiple areas

How severe is the pain on a scale of 1 to 10 with 10 being the worst pain imaginable?

Circle one    0    1    2    3    4    5    6    7    8    9    10

What makes the problem worse? \_\_\_\_\_

What makes the a problem better? \_\_\_\_\_

Does the problem/pain occur at any particular time of the day?     Yes     No     Not sure

If so when does it occur? (check all that apply)     Morning     During day     After work  
 At night     All the time    Other \_\_\_\_\_

Have you been seen or treated for this problem before?     Yes     No

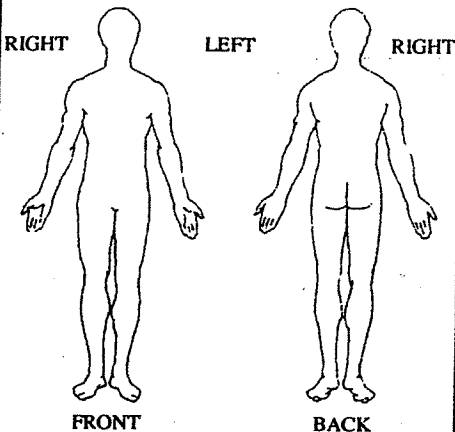
If so by whom? \_\_\_\_\_

What treatments have you had?     None     Medicine     Physical Therapy     Surgery  
 Other \_\_\_\_\_

Did any of these treatments help?     Yes     Yes, but it came back     Partially  
 No

Have you had anything like this in the past?     Yes     No     Not sure

Please place an X on the areas where you feel pain on the picture below.



**NOTES**

Staff use only

Reviewed by

Initials

Date

Initials	Date