Medical History Form

Name: _____ Date of Birth:_____ Today's Date:_____

Primary Care Physician (PCP):_____

Referring Physician, if applicable:_____

What brings you in, and how long has it been a problem? (E.g.: "Left wrist pain for 1 month")

_____

Did the problem result from an injury? ☐ No ☐ Yes, Date of injury: _____

Is this a work related injury? ☐ No ☐ Yes, Date of injury: _____

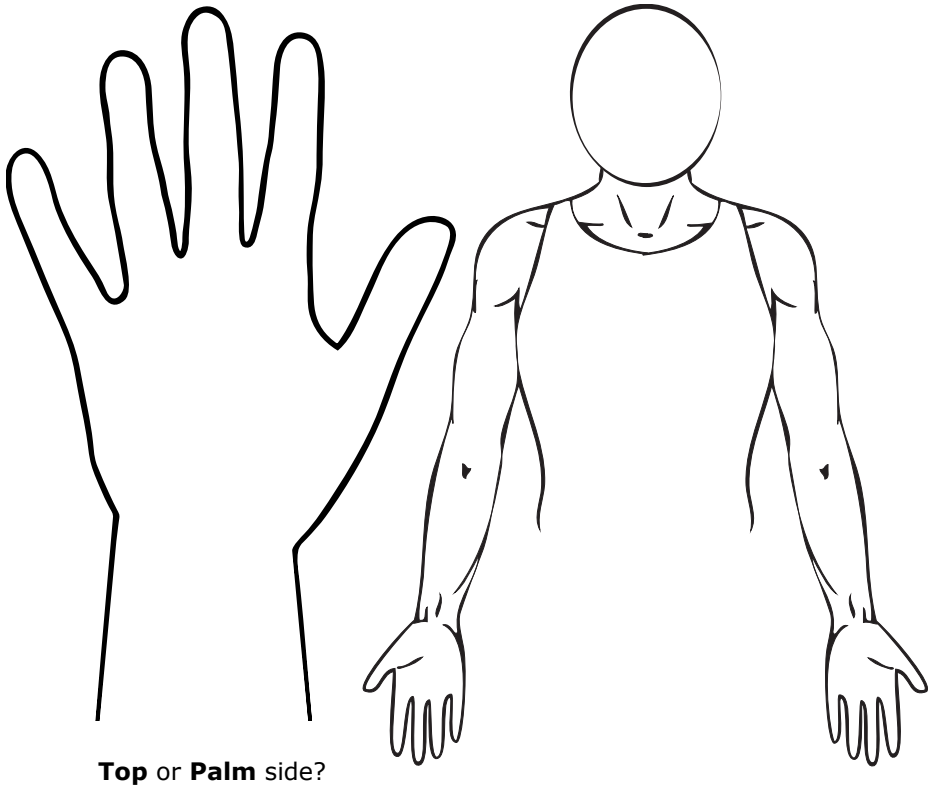
Length of time with employer? _____ Has the injury been reported? ☐ No ☐ Yes

Can you describe the injury, or how the problem started?

_____

Symptoms:

Please label the diagrams with your symptoms:
P - Sharp Pain
A - Aching/Soreness
L - Locking/Catching
G - Grinding
D - Dislocation/Instability
S - Stiffness
N - Numbness
T - Tingling
B - Burning
W -Weakness
O - Other _____



Top or **Palm** side?

Duration: How long have you had symptoms? When do symptoms occur?

_____

Timing: How often do you have symptoms? ☐ Always ☐ Daily ☐ Weekly ☐ Other_____

Severity: (rate 0=none, 10=severe, please circle)

At worst 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

At best 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

What makes your symptoms better?_____ Worse? _____

Have you had any prior injuries to the area? ☐ No ☐ Yes: _____

Please complete page 2 on opposite side.

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Previous Treatment:

☐ None ☐ Physical Therapy ☐ Splinting/Bracing ☐ Medications:
☐ Injections ☐ Chiropractor ☐ Surgery:

Did any of these treatments provide relief? ☐ No ☐ Yes: _____

Medical History:

Are you pregnant? ☐ Yes ☐ No ☐ Possibly

Please check previous or current medical conditions:

☐ None

☐ Anemia	☐ Diabetes	☐ Liver Disease	☐ Arthritis
☐ Heart Disease/CAD	☐ Osteoporosis	☐ Asthma	☐ Hepatitis
☐ Prostate	☐ Blood Clots/DVT	☐ High Blood Pressure	☐ Stomach Ulcer/Reflux
☐ Cancer	☐ High Cholesterol	☐ Stroke/Seizures	☐ COPD/Lung Disease
☐ HIV	☐ Thyroid Disease	☐ Depression	☐ Irregular Heartbeat
☐ Vascular Disease	☐ Gout	☐ Psoriasis	☐ Other: _____

Surgical History: (Please list previous surgeries/operations and dates)

☐ None

_____ _____ _____

_____ _____ _____

Current Medications: (Please list the names of the drugs you are taking)

☐ None

_____ _____ _____

_____ _____ _____

Allergies to Medications: (Please list the drug name and reaction)

☐ None

_____ _____ _____

Osteoporosis: Have you undergone a bone scan or DEXA scan within the past 2 years?

☐ No ☐ Yes, with the results showing:_____

Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: _____ Hobbies: _____

Tobacco use? ☐ No ☐ Yes _____ packs/day for _____ years

Alcohol use? ☐ No ☐ Rare ☐ Social ☐ Daily

Illegal drug use? ☐ No ☐ Yes _____

Family History of Medical Conditions: (Please list any medical problems that run in your family)

☐ None

_____

Review of Systems: Are you ***currently*** experiencing any of the following symptoms? (Please check all that apply)

No	Yes					
☐	☐	**General**:	☐ Fatigue	☐ Weight gain/loss	☐ Fever/Chills	☐ Insomnia
☐	☐	**Head/Throat:**	☐ Vision change	☐ Hearing loss	☐ Sinus pain	☐ Sore throat
☐	☐	**Cardiovascular**	☐ Chest pain	☐ Palpitations	☐ Edema	☐ Poor circulation
☐	☐	**Respiratory**	☐ Cough	☐ Short of breath	☐ Wheezing	☐ Pneumonia
☐	☐	**Gastrointestinal**	☐ Nausea/vomiting	☐ Indigestion	☐ Acid reflux	☐ Stomach pain
☐	☐	**Genitourinary**:	☐ Frequent urination	☐ Difficult to urinate	☐ Painful to urinate	☐ Bloody urine
☐	☐	**Skin**	☐ Rash	☐ Hives	☐ Sensitive skin	☐ Easy scarring
☐	☐	**Neurological**	☐ Headache	☐ Dizziness	☐ Seizures	☐ Tremor
☐	☐	**Psychiatric**	☐ Depression	☐ Anxiety	☐ Mood swings	☐ Stress
☐	☐	**Endocrine**	☐ Hypoglycemia	☐ Diabetes	☐ Thyroid	☐ Hot Flashes
☐	☐	**Hematological**	☐ Easy bruising	☐ Easy bleeding	☐ Anemia	☐ Blood clots
☐	☐	**Immunologic**	☐ Seasonal allergies	☐ Food Allergies	☐ Frequent infection	☐ HIV

Patient Signature:_____ Date:_____

Physician Signature:_____ Date:_____