

MEDICAL HISTORY FORM

NAME _____ TODAYS DATE _____

BIRTHDATE _____ AGE _____ HEIGHT _____ WEIGHT _____

MAIN COMPLAINT _____ LEFT OR RIGHT SIDE _____

WORK RELATED? YES OR NO ARE YOU WORKING? YES OR NO DATE SYMPTOMS BEGAN _____

LAW SUIT INVOLVED? YES OR NO ATTORNEY NAME _____

PRIMARY CARE PHYSICIAN: _____

REFERRED BY: _____

LIST ANY ALLERGIES YOU HAVE TO DRUGS, FOOD OR OTHER ITEMS _____

LIST ANY MEDICATIONS YOU ARE NOW TAKING: _____

MEDICAL PROBLEMS (i.e. high blood pressure): _____

LIST ALL OPERATIONS: YEAR _____ HOSPITAL _____ DOCTOR _____

REVIEW OF SYSTEMS (CHECK ALL ITEMS THAT APPLY) DESCRIBE,

LOCATION OF PAIN _____

CONSTITUTIONAL-WEIGHT LOSS/GAIN, LOSS OF HAIR _____

SEVERITY 0 1 2 3 4 5 6 7 8 9 10

EAR/NOSE/THROAT PROBLEMS _____

WHEN DOES IT OCCUR _____

GASTRO-INTESTINAL SYSTEM PROBLEMS _____

DESCRIBE THE PAIN _____

GENITO-URINARY SYSTEM PROBLEMS _____

WHAT MAKES IT WORSE _____

INTEGUMENTARY PROBLEMS (CANCER, LESIONS) _____

WHAT MAKES IT BETTER _____

ENDO PROBLEMS (DIABETIC, THYROID) _____

HOW LONG DOES IT LAST _____

HEMI/LYMPH SYSTEM PROBLEMS _____

ANY ASSOCIATED SIGNS _____

EYE PROBLEMS _____

MUSCULOSKETETAL SYSTEM PROBLEMS _____

OCCUPATION _____

NEUROLOGIC SYSTEM PROBLEMS _____

MARITAL STATUS SINGLE MARRIED WIDOWED DIVORCED

IMMUNOLOGY PROBLEMS _____

OF CHILDREN _____

RESPIRATORY SYSTEM PROBLEMS _____

PRIOR JOB IF RETIRED _____

PSYCHIATRIC PROBLEMS _____

DO YOU SMOKE? _____ #PER DAY _____ YEARS SMOKED _____

PSYCHIATRIC PROBLEMS _____

DO YOU DRINK ALCOHOL _____ DRINKS PER DAY _____

ANEMIA OR BLOOD DISORDERS _____

