Medical History

MRN:_____

Today's Date:_____

Name: _____ Age: _____ Date of Birth:_____

Gender:_____ Height_____ Weight:_____ Preferred Language:_____

Referring Physician: _____ Phone: _____

Address:_____

Primary Care Doctor: _____ Phone: _____

Address:_____

Pharmacy Name: _____ Phone: _____

Address:_____

What is the reason for your visit today? _____

Location of pain (include side): _____ **Are you right or left hand dominant?** _____

How long has it been present?_____ **Describe pain:** dull_____ sharp_____ tingling_____ other_____

When does pain occur? at rest _____ with activity _____ at night _____ other _____

Any other symptoms associated with current problem? _____

Severity: on a scale from 1-10, indicate how severe the pain is on the scale below with 1 being very little pain to 10 being excruciating/can't function (circle number): 1 2 3 4 5 6 7 8 9 10

Indicate what makes it better? pain medicine_____ ice_____ heat_____ rest_____ elevation_____

Context: How did it occur? _____

If result of injury, date occurred _____ Is it better? _____ Is it worse? _____

PAST MEDICAL HISTORY: Please list past medical conditions below

_____

_____

_____

Asthma	____No	____Yes	DVT/PE (Blood Clot)	____No	____Yes
Blood or plasma transfusions	____No	____Yes	Heart Disease	____No	____Yes
Cancer	____No	____Yes	Lung disorder	____No	____Yes
Cholesterol	____No	____Yes	Stomach/Intestinal disorder	____No	____Yes
Clotting disorder	____No	____Yes	Thyroid problems	____No	____Yes
Diabetes	____No	____Yes			
Hypertension	____No	____Yes	*Other:_____		

PAST SURGICAL HISTORY: Please list any surgeries you have had:

Type of Surgery	Approx. Date	Complications if any

Name: _____ Date of Birth: _____ MRN: _____

Have you ever had general anesthesia? _____
Have you had any problems with anesthesia? _____ **Describe:** _____

MEDICATIONS, VITAMINS, SUPPLEMENTS & HERBS: Please list all medications, vitamins, supplements and herbs you are currently taking including dosage in the lines below:

Name	**Dosage/Amount**

ALLERGIES: Please list allergies and reaction or write "NONE"(include medications, environmental agents, food, other)

Allergy	**Reaction**	**Allergy**	**Reaction**

SOCIAL HISTORY:

Occupation: _____ Marital Status: _____

Home: 1 story ____ 2 story ____ entrance steps ____ apartment ____ elevator ____

Do you exercise regularly? ____ Involved in school sports? ____

Are you a tobacco user? _____ Cigarettes? ____ Cigars? ____ Smokeless Tobacco? ____ Other? _____

Average per day? ____ # of years? ____ If no, have you ever? ____

Do you currently consume alcohol? ____ Average # per wk? ____ If no, have you previously? ____

Do you currently use drugs? ____

FAMILY HISTORY: Please indicate any major conditions/illnesses for family members below.

Relative	**Alive (age)**	**Deceased (age)**	**Cause of Death**	**Health Problems**
Mother				
Father				
Siblings				
Other				

REVIEW OF SYSTEMS:

Are you currently having or have you had problems with your:

(If yes, check box to right of symptoms that apply)

Constitutional	No / Yes	Fatigue☐ Headache☐ Fever☐ Weight Loss☐ Other:_____
Eyes	No / Yes	Glasses☐ Blurred vision☐ Other: _____
Ears,Nose,Throat	No / Yes	Congestion☐ Hearing Loss☐ Jaw discomfort☐ Other:_____
Lungs, Breathing	No / Yes	Cough☐ Wheezing☐ Shortness of breath☐ Other:_____
Heart	No / Yes	Heat murmurs☐ Irregular heartbeat☐ Other:_____
Gastrointestinal	No / Yes	Nausea☐ Vomiting☐ Stomach aches☐ Constipation☐ Diarrhea☐ Other:_____
Bladder	No / Yes	Incontinence☐ Urinary tract infections☐ Difficulty urinating☐ Other:_____
Endocrine	No / Yes	Diabetes☐ Thyroid problems☐ Delays in growth☐ Other:_____
Musculoskeletal	No / Yes	Joint pain☐ Leg pain☐ History of broken bones☐ Other: _____
Bleeding	No / Yes	Anemia☐ Prolonged Bleeding after cut/injury☐ Other:_____
Neurological	No / Yes	Dizziness☐ Numbness/tingling☐ Headaches☐ Frequent falls☐ Other:_____
Integumentary	No / Yes	Rashes☐ Skin Disorders☐ Connective tissue disorders☐ Other:_____
Psychiatric	No / Yes	Change in mood or behavior☐ Change in sleep patterns☐ Other:_____
Immunologic/ Allergic	No / Yes	Asthma☐ Hay fever☐ Chronic rashes☐ Communicable Diseases☐ Other:_____

_____ _____

Signature (Person Completing Form) Date Completed

_____ _____

Physician Signature Date

WORKER'S COMPENSATION & NO FAULT

If this problem is related to a work or car Accident, please complete the following questions:

Work related?_____ Car accident related?_____ Date of accident/onset _____

Which part(s) of your body was injured (include side)? _____

Prior to this accident, did you have a problem/pain in the affected area? _____

Did you sustain other injuries due to this accident? _____ If yes, please give details (ex: left hand laceration):

_____

Did you have immediate pain of the affected area at the time of the accident or a few days later? _____ Where (address with state) and how did the injury occur? _____

_____

Job title on date of injury _____

What were your usual work activities on the date of the injury/onset? _____

Employer when injury occurred (include address and phone #):_____

Have you been treated by another health care provider for this injury? If so, give details _____

_____

Are you currently working? _____ If Yes, regular or modified duties (if modified, give details)? _____

_____

If you are Not working, what is the date you first missed work due to this injury? _____

Are you being counseled by a lawyer for this injury? _____

If car accident, where you the driver or passenger? _____

Did the air bag deploy? _____ Where you wearing your seat belt at the time of the accident? _____

_____ _____

Signature (Person Completing Form) Date Completed