

Medical History Form

Today's Date: _____

Name: _____

First MI Last

Height: _____ Weight: _____ Heart Rate: _____

Hand Dominance: Left Right Both

What is your pain on a scale of 1-10 (10 being the worst) ___/10 Activity ___/10 Rest

Chief Complaint:

Problem that brings you to our facility: _____

Previous treatment for this problem: _____

List the Body Part (Example: Knee, Wrist): _____ Left-side Right-side

Date of Injury/Onset: _____ Is this a Workman's Compensation injury? YES NO

MM/DD/YYYY

General Medical History:

Neurological

Stroke	YES	NO
Migraine	YES	NO
Concussion	YES	NO
Peripheral Neuropathy	YES	NO
Epilepsy	YES	NO

Cardiovascular

Heart Attack	YES	NO
High Blood Pressure	YES	NO
Coronary Artery disease	YES	NO
Elevated Cholesterol	YES	NO

Kidney

Renal Insufficiency	YES	NO
Kidney Stones	YES	NO

Gastrointestinal

Ulcers	YES	NO
Reflux	YES	NO

Skin

Psoriasis	YES	NO
Eczema	YES	NO

Endocrine

Diabetes	YES	NO
Thyroid Disease	YES	NO
Prednisone Use	YES	NO

Pulmonary

Asthma	YES	NO
Emphysema	YES	NO
COPD	YES	NO
Pulmonary embolism	YES	NO

Infectious

HIV/AIDS	YES	NO
Hepatitis B	YES	NO
Hepatitis C	YES	NO
TB	YES	NO
Recent tick Bite	YES	NO

Cancer

Type:	YES	NO
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Musculoskeletal

Osteoarthritis	YES	NO
Rheumatoid Arthritis	YES	NO
Fibromyalgia	YES	NO
Osteoporosis	YES	NO
Gout	YES	NO

Hematological

Bleeding problems	YES	NO
Bood Clots	YES	NO
Anemia	YES	NO
Blood Transfusion	YES	NO

Psychological

Depression	YES	NO
Anxiety	YES	NO
ADHS	YES	NO
Bipolar	YES	NO
Claustrophobia	YES	NO

Problem Not Listed

Explain:	YES	NO
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Medical History Form

Previous Surgery/Hospitalizations:

No history of surgery.

<i>List surgery/Reason for hospitalization:</i>	<i>Hospital/Facility:</i>	<i>Date:</i>
1. _____	a. _____	b. _____
2. _____	a. _____	b. _____
3. _____	a. _____	b. _____
4. _____	a. _____	b. _____
5. _____	a. _____	b. _____
6. _____	a. _____	b. _____

Have you ever had General Anesthesia? YES NO

Have you ever had any problems with anesthesia? YES NO

If YES, please explain: _____

Current Medications: (List any prescription, drugs, and/or non-prescription medications, including vitamins, nutritional supplements, or anything taken orally.)

I do not take any medications.

<i>List names of medications:</i>	<i>Dose or strength:</i>	<i>Reason for medication:</i>
1. _____	a. _____	b. _____
2. _____	a. _____	b. _____
3. _____	a. _____	b. _____
4. _____	a. _____	b. _____
5. _____	a. _____	b. _____
6. _____	a. _____	b. _____
7. _____	a. _____	b. _____
8. _____	a. _____	b. _____
9. _____	a. _____	b. _____
10. _____	a. _____	b. _____

Allergies:

I have NO Allergies to Medications.

<i>List medications or Allergens:</i>	<i>Describe reaction:</i>
1. _____	a. _____
2. _____	a. _____
3. _____	a. _____
4. _____	a. _____

Are you allergic to Latex? YES NO

