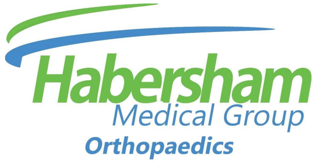

MEDICAL HISTORY INFORMATION – Please Print. All information is confidential.

Reason for being seen today____ Left ____ Right ____

How long have you had this problem? ____

Date of injury ________________ Where were you when you got hurt? ____

Describe how injury occurred ____

Have you seen another Doctor for this problem______ Name of Doctor for this problem_____________________________

Has problem gotten better or worse over time ____

Describe your pain ____

Frequency of pain _____________________________________ Severity of pain (1-10 scale with 10 being worst) ____________

Have you ever had a previous problem in this area? ____

Pharmacy Name: ___________________________________ City ___________________ Phone # _____________________

Medication/Supplements Dose:
Frequency: Reason for Medication:

______________________________________ _________ ____________
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______________________________________ _________ ____________
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______________________________________ _________ ____________
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______________________________________ _________ ____________
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______________________________________ _________ ____________
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______________________________________ _________ ____________
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______________________________________ _________ ____________
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Are you currently in a Pain Clinic? Yes No Name of Pain Clinic ____

Height ____________________ Weight ______________________

Are you pregnant or is there a possibility you may be pregnant? Yes No

Social History:
Marital Status Single ______ Married ______ Separated ______ Divorced ______ Widowed ______

Use of Alcohol Never ______ Rarely _______ Moderate ______ Daily _______
Use of Tobacco Never ______ Current pack/day ______________ Previously but quit ______________

Family Medical History:

	Age	Diseases	If Deceased, cause of death
Father	_______	______________________________	__________________
Mother	_______	______________________________	__________________
Siblings	_______	______________________________	__________________
Children	_______	______________________________	__________________

Review of Systems - Please circle any that apply:

Constitutional: Appetite Change Fever Weight Gain Weight Loss Excessive Sweating Night Sweats Fatigue

Musculoskeletal: Back Pain Joint Pain Joint Swelling Muscle Aches Muscle Weakness Stiffness Limited Range of Motion

Neurologic: Abnormal Gait Loss of Coordination Focal Weakness Seizures Slurred Speech Tremors Numbness Memory Problems Headaches

Respiratory: Cough Wheezing

Cardiovascular: Swollen Legs/Feet

Ear, Nose, Mouth, Throat: Hearing Loss Oral Lesions Oral Pain Nasal Discharge

Gastrointestinal: Abdominal Pain Diarrhea Vomiting Change in Stool Nausea

Endocrine: Excessive Thirst Excessive Hunger Excessive Urination

Hematologic/Lymphatic: Bruising Excessive Bleeding Easy Bleeding Enlarged Lymph Nodes Recurrent Infections

Psychiatric: Confusion Mood Changes Depression Sleep Disturbances

Past Medical History: Have you ever had the following (circle Yes for any that apply)

Measles - - - - - - - yes Anemia - - - - - - - - yes Back trouble - - - - - - - - yes Hepatitis A,B or C - - yes
Mumps - - - - - - - yes Heart Attack - - - - - yes High blood Pressure - - - yes Ulcers - - - - - - - - - - yes
Chickenpox - - - - yes Epilepsy - - - - - - - - yes Low blood Pressure - - - yes Kidney Infections - - - - yes
Atrial Fibrillation - - yes Bronchitis - - - - - - - yes Pulmonary Embolus - - - yes Thyroid Disease - - - yes
Rheumatoid Arthritis yes Tuberculosis - - - - - yes Asthma - - - - - - - - - - - yes Migraines - - - - - - - - yes
Blood Clot/DVT - - - yes Diabetes - - - - - - - - yes Hives or Eczema - - - - - yes Pneumonia - - - - - - - yes
Urinary Disease yes Cancer - - - - - - - - - yes Gout - - - - - - - - - - - - - yes Pacemaker - - - - - - - - yes
Bleeding Disorder yes Sleep Apnea - - - - - yes Inflammatory Arthroplasty yes Chest Pain/Angina - - - - yes
Rheumatic Fever - yes Glaucoma - - - - - - - yes Lupus/SLE - - - - - - - - - yes Congestive Heart Failure yes
Heart Murmur - - - yes Hernia - - - - - - - - - yes Mitral Valve Prolapse - - yes Chronic Infections (MRSA) yes
Arthritis - - - - - - - yes Blood or Plasma Stroke - - - - - - - - - - - - yes Emphysema - - - - - - - - - yes

COPD - - - - - - - - yes Transfusions - - - - - yes HIV/AIDS - - - - - - - - - yes High Cholesterol - - - - - - yes

Are you allergic to any of the following: (circle any that apply):

Penicillin Codeine Aspirin Acetaminophen Sulfa Latex Tape Betadine/Iodine

Please list any additional allergies (food, metal, drug) ____

Have you ever had any problems receiving anesthesia? Yes No

Previous Hospitalizations/Surgeries/Serious Illnesses Date? Hospital, City, State

____ __________ ____

____ __________ ____

____ __________ ____

____ __________ ____