

MEDICAL HISTORY
PLEASE FILL OUT COMPLETELY!

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

HISTORY & PRESENT ILLNESS:

What are you seeing the Doctor for? (Please be Specific):

Date of Injury? _____

How long have you had these symptoms? _____

PAST MEDICAL HISTORY:

All Previous Medical Problems and Hospitalizations:

- Yes___ No___ Rheumatic Fever **When** _____
- Yes___ No___ Childhood Diseases **Circle** (measles, mumps, pox, ext.) **When** _____
- Yes___ No___ Allergies, hives or drug reactions **When** _____
- Yes___ No___ Asthma **When** _____
- Yes___ No___ Diabetes **When** _____
- Yes___ No___ Thyroid Problems **When** _____
- Yes___ No___ Bronchitis, Emphysema **When** _____
- Yes___ No___ Stroke **When** _____
- Yes___ No___ Heart Attack **When** _____
- Yes___ No___ High Blood Pressure **When** _____
- Yes___ No___ Murmurs **When** _____
- Yes___ No___ Ulcers **When** _____
- Yes___ No___ Migraines **When** _____
- Yes___ No___ Sexually transmitted diseases **When** _____
- Yes___ No___ Cancer **When** _____

Other Problems not listed above:

PAST SURGICAL HISTORY:

Have you had any previous surgeries?

Procedures:	Date:	Name of Physician:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any Previous Fractures?

When _____ Type of Fracture _____

Do you use a Walker, Cane, or Brace, if so which one? _____

Read and Reviewed: _____ Date _____

(Physician Signature)

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

MEDICATION:

What Medications are you **Currently** taking?

Name:	Doses:	Times/Day:	Reason:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are You Allergic to **ANY** Medications? If so What?

SOCIAL HISTORY:

Have you ever Smoked? _____ How many Packs a day? _____ How many years? _____
When did you quit? _____

Do You Drink Alcoholic Beverages? _____ How Often? _____

Have You Lost Weight Recently? _____

Have You Had Faintness, Numbness, and Convulsions? _____

Do You Use Drugs? (Marijuana, LSD, Heroin, Cocaine) _____

Do You Live Alone or with Family? _____

Do You Drive? _____

Occupational Duties: _____

FAMILY HISTORY:

(PLEASE CHECK)

- ___ Frequently Broken Bones Family Member _____
- ___ Diabetes Family Member _____
- ___ Heart Disease Family Member _____
- ___ Heart Attack Family Member _____
- ___ Asthma Family Member _____
- ___ Cancer Family Member _____
- ___ Ulcer Family Member _____
- ___ High Blood Pres Family Member _____
- ___ AIDS/HIV Family Member _____
- ___ Hepatitis Family Member _____
- ___ Kidney/Bladder Family Member _____
- ___ Kidney Stones Family Member _____
- ___ Blood Urine Family Member _____

Read and Reviewed: _____ Date _____

(Physician Signature)

