

**MEDICAL HISTORY FORM**

Today' Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Handedness? R L Pregnant? Y N

Reason for today's visit: \_\_\_\_\_ Side Involved: R L  
How did symptoms first occur? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have symptoms been present? \_\_\_\_\_

On a scale from 1 – 10 (with 10 being the worst), circle the number that best describes the pain/symptoms:

**1 2 3 4 5 6 7 8 9 10**

If injury: Date: \_\_\_\_\_ Place: \_\_\_\_\_

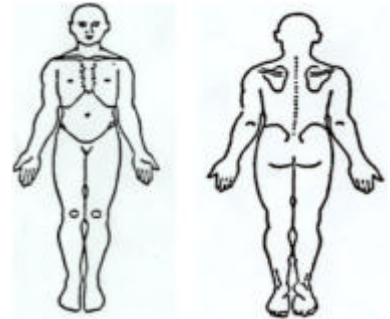
Work Related: Y N

Have you been treated elsewhere: Where? \_\_\_\_\_

By Whom? \_\_\_\_\_

X-rays/MRIs/Scans taken? Y N Where? \_\_\_\_\_  
\_\_\_\_\_

Please indicate where symptoms are present:



Medication allergies? \_\_\_\_\_  
\_\_\_\_\_

Anti-inflammatory use (list all taken): \_\_\_\_\_

List all medications you are taking and dosages: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all previous surgeries: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who is your Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Personal Habits:	Y	N	Amount		Y	N	Amount
Drink Alcohol			_____	Exercise Regularly			_____
Smoke			_____	Wear Seat Belts			_____
Chew Tobacco			_____				

I hereby certify that to the best of my knowledge any accident/injury information stated above is correct.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Personal/Family Medical History:

Please mark if **you** have any of the following:

Please mark if a **family member** has any of the following:

	Please mark if <b>you</b> have any of the following:	Please mark if a <b>family member</b> has any of the following:
<b>General:</b>		
Problems with anesthesia		
Cancer		
Environmental Allergies		
<b>Endocrine:</b>		
Diabetes		
Thyroid Disease		
<b>Hematology:</b>		
Anemia		
Bleeding Disorders		
<b>Infectious Diseases:</b>		
T.B.		
Hepatitis		
Lyme Disease		
Other:		
<b>Cardiovascular:</b>		
High Blood Pressure		
Chest Pain/Angina		
Congestive Heart Failure		
Heart Attack		
Heart Murmur		
Irregular Heart Beat		
DVT		
Phlebitis		
Swelling of Feet		
<b>Pulmonary:</b>		
Asthma		
Emphysema/COPD		
Pneumonia		
Chronic Cough		
Pulmonary Embolism	€	€
<b>Gastrointestinal:</b>		
Ulcers		
Gastric Reflux (GERD)		
Irritable Bowel Syndrome		
<b>Renal:</b>		
Kidney disease		
Kidney Stones		
<b>Musculoskeletal:</b>		
Arthritis		
Back Disorders		
Backache		
Osteoporosis		
<b>Neurological:</b>		
Headaches		
Dizziness		
Blurred Vision/Double Vision		
Epilepsy/Convulsions/Seizures		
Stroke		
Nervous Disorder		
Peripheral neuropathy		

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_