# Medical History

Name _____ Date of Birth _____

## Chief Complaint

What brings you in today? _____

What body part are you here for today? ☐ Right / ☐ Left _____

When did your symptoms begin? _____

If accident, date: ____/____/____ where did it occur: ☐ Auto ☐ Work ☐ Other: _____

Attorney Name _____ Phone: _____ Fax _____

Employer Name _____ Phone: _____ Fax _____

Employer Address _____

Occupation _____

Tell us about your PAIN

Where does it hurt? (Front, back, inside, outside) _____

How bad does it hurt? (0-10 with 0 being no pain) _____

When does it hurt? (Constant, comes and goes, morning/ night) _____

Does anything make it feel worse? _____

Does anything make it feel better (e.g., medication)? _____

Circle all words/phrases that are associated with your symptoms:

| | | | |
|---|---|---|---|
| burning | radiating | pins and needles | numbness |
| sharp | dull | aching | deformity |
| swollen | warm | red | giving way |
| getting better | getting worse | staying the same | |

Has this problem been evaluated by a healthcare provider? YES NO

If yes, who did you see? _____

What did they do for you? (x-rays, splint, etc.)
_____

**Height_____ Estimated Weight _____ Dominant Hand: Right / Left**

## MEDICATIONS

Include non-prescription, such as aspirin, herbal medications, vitamins

| Medication | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

If you are taking more medications, circle Yes and ask for an additional sheet of paper

## ALLERGIES

| Medication | Describe Reaction (If known) |
|---|---|
| | |
| | |
| | |
| | |
| | |

Are you allergic to shellfish or iodine? ☐ No ☐ Yes

## SURGERIES

| Surgeries | Date | Complications |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

History of Fractures: _____
Have you ever had general anesthesia? ☐ No ☐ Yes
Have any problems with anesthesia? ☐ No ☐ Yes If yes, describe: _____

## MEDICAL HISTORY

Please circle all that apply

| | | |
|---|---|---|
| Arthritis | Heart Disease | Kidney Stones |
| Asthma | High Blood Pressure | Stroke |
| Cancer | High Cholesterol | Thyroid Disorder |
| Diabetes | HIV | Other (please list) |

**Signature**: _____ **Date**: _____

## FAMILY HISTORY

| Member | Alive/Deceased | Age: Now or at the time of death | Major medical problems or cause of death |
|---|---|---|---|
| Father | A D | | |
| Mother | A D | | |
| Sister/Brother | A D | | |
| Son/ Daughter | A D | | |
| | | | |
| | | | |

Are there any family members with similar problems to yours? If yes, please describe:
_____

## SOCIAL HISTORY

Smoking Status: ☐ Never Smoked ☐ Current Smoker ☐ Previous Smoker
If currently smoking: How many cigarettes per day _____ for _____ year(s)
Nicotine products currently using:
☐ Cigars ☐ Chewing Tobacco ☐ E-Cigarette/Vape ☐ Gum/Patch
If previous smoker: When did you quit: ☐ This year ☐ >1 year ☐ >5 years ☐ >10 years
How many cigarettes per day _____ for _____ year(s)

Drink alcohol: ☐ No ☐ Yes
If yes, how many drinks _____ per day or _____ per week

History of substance addiction: ☐ No ☐ Yes
If yes, what substance _____ when _____
Did you receive treatment? ☐ No ☐ Yes

Do you and your passengers always wear a seatbelt? ☐ No ☐ Yes
Do you always wear a helmet while on a bicycle or motorcycle? ☐ No ☐ Yes ☐ N/A

## WORK HISTORY

Currently working?
☐ **NO**: ☐ Retired ☐ Medically disabled ☐ **YES:** ☐ Full-time ☐ Part-time
Restrictions: ☐ No ☐ Yes If Yes, please explain: _____
Job Title: _____

**Signature**: _____ **Date**: _____

# REVIEW OF SYMPTOMS

Please check all that apply

Constitutional:
_____ Fever
_____ Weight Loss
_____ Other
_____

Eyes:
_____ Eye Pain
_____ Blurred Vision
_____ Double Vision
_____ Other
_____

Ear, Nose Throat:
_____ Hearing Loss
_____ Pain
_____ Other
_____

Cardiovascular:
_____ Chest Pain
_____ Shortness of Breath
_____ Irregular Heartbeat
_____ Other
_____

Neurologic:
_____ Numbness
_____ Tingling
_____ Weakness
_____ Other
_____

Respiratory:
_____ Coughing
_____ Wheezing
_____ Asthma
_____ Other
_____

Gastrointestinal:
_____ Diarrhea
_____ Constipation
_____ Stomach Pain
_____ Ulcers
_____ Other
_____

Hematological/Lymphatic:
_____ Anemia
_____ Free Bladder
_____ Swollen Lymph Nodes
_____ Other
_____

Integumentary (skin)
_____ Rashes
_____ Lesions
_____ Masses
_____ Other
_____

Musculoskeletal:
_____ Joint Swelling
_____ Arthritic Condition
_____ Osteoporosis
_____ Bursitis or Tendonitis
_____ Gout or Joint Infection
_____ Other
_____

**Signature**: _____ **Date**: _____