Patient Medical History

Today's Date: _____

First Name: _____ **Middle:** _____ **Last Name:** _____

Date of Birth: _____ **Age:** _____ **HI:**_____ **WI:** _____

Are you: ☐Right Handed ☐Left Handed

Main Reason for Visit? ☐Numbness ☐ Pain ☐ Mass ☐ Weakness ☐ Other

What part of the body is involved? _____ ☐ Left Side ☐ Right Side

How long has this problem existed? _____ (write number) ☐ Weeks ☐ Months ☐ Years

The severity of your pain is : ☐ Mild ☐Moderate ☐ Severe

Describe pain: ☐ Sharp ☐ Burning ☐Dull Ache Does the pain wake you at night? ☐Yes ☐No

When do you experience pain? _____

Visit is the result of an injury from : _____

Date of Injury: _____ Describe: _____

Do you have legal representation related to the condition for which you are being seen today? ☐Yes ☐No

If yes, please provide Name and address of attorney: _____

Did you bring imaging studies: ☐ X-Ray ☐ MRI ☐ CT ☐ Other _____

Are you a diabetic? ☐Yes ☐No Treatment: ☐Insulin ☐ Oral Meds ☐ Diet ☐ None

Are there any blood thinners? ☐Yes ☐No How long? _____ ☐ Weeks ☐ Months ☐ Years

If yes, list: _____

Social History

Occupation: _____ **Are you currently working?** ☐Yes ☐No

If no, how long off work: _____

Exercise? ☐ Never ☐ Rarely ☐ Daily ☐ Weekly ☐ Monthly

Special Diet? ☐Yes ☐No Describe: _____

Do you smoke? ☐Yes ☐No If yes, how many packs per day? _____ For how many years? _____

Quit Smoking? ☐Never Smoked ☐This Year ☐> 1 Year ☐> 5 years ☐ >10 years ____ packs for ____ years

Drink alcohol? ☐ None ☐ Daily ☐1-2x/week ☐ 1-2x/month ☐ 1-2x/year

History of substance abuse? ☐Yes ☐No Describe: _____

Surgeries/Hospitalizations	Year	Complications

Please list all medications, including the doses that you are currently taking.

(Please include any and all Prescriptions, Over the Counter, Vitamins, Herbs, etc.)

Medications	Dose	Medications	Dose

Allergies: Do you have any allergies to medications, foods, or other substances? ☐Yes ☐No

If yes, please list:

Allergy to:	Reaction:

Have you ever had a reaction to anesthesia? ☐Yes ☐No

Review of Symptoms: Are you currently having or have you had problems with the following in the past:

Symptom	Yes	No	Describe All YES Responses:
Blurred Vision, double vision, cataracts, glasses, contacts			
Asthma, cough, pneumonia			
Short of breath, TB			
Stomach ulcer, hepatitis, blood in stool			
Painful Urination, kidney disease, blood in urine			
High blood pressure			
Heart Problems, Blood Clots			
Balance Problems			
Epilepsy, Seizures, Stroke			
Blackout/Fainting, Headaches			
Numbness, Tingling, Weakness			
Prior Fracture, Osteoporosis			
Arthritis, Joint Swelling, Back Pain			
Polio			
Depression, Nervousness, Sleep Disorders			
Cancer			
Fevers, Chills Night Sweats			
Easy Bleeding, Bruising, Anemia			
Blood Transfusions			
Skin Ulcers, Rash, Lumps			
HIV/Aids			
Other			
Thyroid Disorder, Excessive Thirst			

Family History

Member	Alive	Deceased	Age	Health Status/Cause of Death
Grandparents				
Father				
Mother				
Sister/Brother				
Sister/Brother				
Sister/Brother				

I understand that any person who knowingly and with intent to defraud any insurance company or other persons, files, and statement of claim containing any materially false information or who conceals, for the purpose of misleading, information concerning any fact, commits a fraudulent act, which is a crime subject to criminal prosecution and civil penalties.

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____