MEDICAL HISTORY

Patient Name____ **Date**______________________
Date of Birth ________________________

Primary Care Physician: ________________________ Referring MD: ____________________________
Cardiologist: ________________________________ Rheumatologist: ___________________________
List any other specialist you see on a regular basis: ____
Preferred Pharmacy & Location: ______________________________
Age: _________ Height: _________ Weight: _________ Are you Right or Left Handed? __________
What are you being seen here for today? ____
____
Which side? (Right or Left) ______How long has this problem existed? ____________________________
Place of employment: ______________________ Occupation: __________________________________
Job Description: ____

Have YOU ever been diagnosed with the following? Please Check

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Angina
- ☐ Anxiety/Panic Attacks
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bleeding Ulcer
- ☐ Blood Clots,
  where? _____________
- Cancer
  Type? ______________
- ☐ Chronic Fatigue Syndrome
- ☐ Coronary Artery Disease
- ☐ Osteoporosis
- ☐ Depression
- ☐ Diabetes
  do you take insulin? Yes No
- ☐ Drug Abuse
- ☐ Fibromyalgia
- ☐ GERD (Reflux)
- ☐ Gout
- ☐ Heart Attack,
  when? __________
- ☐ Hemophilia/Bleeding
- ☐ Hepatitis A / B / C
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Age of Menopause (if applicable) ___________________________
- ☐ Irregular Heartbeat
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Multiple Myeloma
- ☐ Osteoarthritis
- ☐ Osteomyelitis
  (bone infection)
- ☐ Rheumatoid Arthritis
- ☐ Sarcoidosis
- ☐ Sleep Apnea
- ☐ Stroke
  TIA

  - Have you ever had a bone density test? Yes No If yes, When: __________ Where: ___________
  - Have you fallen in the past year and had an injury due to that fall? Yes No

☐ Other Medical Problem ____

SURGERY HISTORY

Please list ALL surgeries you have had: Date:

____ ____________________
____ ____________________
____ ____________________
____ ____________________

Have you ever had an adverse reaction to anesthesia? Yes No (local or general) Reaction: _______________
Have you ever had a blood transfusion? Yes No When? __________ Why? ______________
If yes, did you have any adverse reaction? Yes No If yes what was it: ____________________
Have you ever been tested for HIV/AIDS Yes No Results: ___________________________________

Do you have any Drug allergies? Yes No Reaction:
Drug: ____ ___________________________
____ ___________________________

Do you have a Latex allergy? Yes No
Please list ALL current medications and dosages (prescription, vitamins & herbal meds): None
Drug: ____ Dose: ______________________
____ ___________________________
____ ___________________________

Have you ever passed out from any type of injection? Yes No

Page 2-Continued
Patient Name____ Date________________________
Date of Birth ________________________

FAMILY HISTORY
Has any BLOOD relative ever been diagnosed with following, please list relationship:
☐ Diabetes ________________ ☐ Heart Attack ________________ ☐ Cancer _____________________
☐ Hemophilia ______________ ☐ Coronary Artery Disease ______________☐ HIV/AIDS ________________
☐ Rheumatoid Arthritis ___________________ ☐ Blood Clots ____________________________________
None of the above

SOCIAL HISTORY
Do you smoke? Yes No Packs per day _____ for _____ years Type: ☐ Cigarettes ☐ Chewing tobacco ☐ Pipe
If tobacco use in the past, what year did you quit: _______________________
Do you currently use alcohol? Yes No Type: ☐ Beer ☐ Wine ☐ Liquor
How many drinks per week ____________ If alcohol use in the past, what year did you quit: ______________
Do you use illegal drugs? Yes No Type: ________ If illegal drug use in past, what year did you quit: _______
Marital Status: Single Married Divorced Widow Separated # of Children: ______
Are you pregnant at this time? Yes No Who lives at home with you?______________________________
Religion: ____________________________

REVIEW OF SYSTEMS

Have you had any trouble with the following over the past 5 years
PLEASE CIRCLE **YES** or **NO** FOR EACH

GENERAL
Unexplained weight loss Yes No

EYES
Glasses Yes No
Contacts Yes No

BREATHING
Coughed up blood Yes No

STOMACH
Blood in stool Yes No
Heartburn Yes No

MUSCLE-BONE
Chronic back pain Yes No
Frequent joint stiffness Yes No

NEUROLOGICAL
Seizures Yes No
Fainting spells Yes No

SKIN
Rashes Yes No

EARS, NOSE, THROAT
Seasonal Allergies Yes No
Hearing Aids Yes No

HEART
Heart Murmur Yes No
Rheumatic fever Yes No

URINARY
Blood in urine Yes No
Can’t hold urine Yes No

VASCULAR
Varicose Veins Yes No
Blood clots Yes No

MENTAL
Trouble sleeping Yes No
Change in Memory Yes No

Is this related to injury/accident? Yes No If yes, please give date and description of injury/accident:
Date:________________Description:____
Related to an Automobile accident? Yes No
Is this injury work related? Yes No
Have you contacted an Attorney? Yes No Attorney’s name: ________________________________
Is this for a second opinion? Yes No Who asked for this second opinion: __________________
Have you seen another Physician for this problem? Yes No Who: ______________________________
Were you seen in the Emergency Department at a Hospital? Yes No When: ________ Where: _________
Have you had X-Rays taken for this problem? Yes No When: _________ Where: ______________