

PATIENT MEDICAL HISTORY FORM

Date Completed: _____ Name: _____ Age: _____ Sex: M F
Height: _____ Weight: _____

Referring Physician (name and phone number): _____

Present Complaint: Rt Lt (indicate body part) _____

Date of Onset: _____ Injury Related: () Yes () No Work Related: () Yes () No

List activities that make it worse: _____

Previous treatment (therapy, injections, medications): _____
When: _____

Treating Physician(s) (name and phone number): _____

Review of Systems:

Weight Loss	() Y () N	Poor Vision	() Y () N	Tingling	() Y () N	Vertigo	() Y () N
Weight Gain	() Y () N	Hearing Loss	() Y () N	Tremors	() Y () N	Weak Muscles	() Y () N
Fatigue	() Y () N	Ringing in Ears	() Y () N	Rashes	() Y () N	Joint Stiffness	() Y () N
Fever	() Y () N	Upset Stomach	() Y () N	Open Sores	() Y () N	Back Pain	() Y () N
Chills	() Y () N	Constipation	() Y () N	Excessive Thirst	() Y () N	Other:	_____
Cough	() Y () N	Bloody Stools	() Y () N	Frequent Urination	() Y () N		_____
Breath Shortness	() Y () N	Diarrhea	() Y () N	Painful Urination	() Y () N	Other joint pain:	_____
Chest Pain	() Y () N	Easy Bruising	() Y () N	Hair Loss	() Y () N		_____
Palpitations	() Y () N	Easy Bleeding	() Y () N	Mood Swings	() Y () N		_____
Leg Swelling	() Y () N	Poor Balance	() Y () N	Anxiety	() Y () N		_____
Blurred Vision	() Y () N	Numbness	() Y () N	Depression	() Y () N		_____

Medications, Vitamins or Supplements & Dosages: () None

Allergies to Medications: () None:

Other Allergies: Metal, Iodine, Shellfish

Social History:

Do you smoke? () Yes () No If yes, : _____ packs per day for _____ years

Do you drink alcohol? () Yes () No If yes, how much? _____

Occupation: _____

Where do you live: (Circle One) Home Apartment Retirement Community

Who do you live with: _____

Reviewed by Provider: _____ Date: _____

Family History: Is there any family history of: (Circle): () **None**
Stroke Heart Disease Diabetes Cancer Arthritis Other: _____

If Yes, Please explain: _____

Past Medical History: Do you have currently or have you ever had?

Anemia:	() Y () N	Elevated Cholesterol:	() Y () N	Liver Disease/hepatitis:	() Y () N
Angina:	() Y () N	Emphysema/COPD:	() Y () N	Pancreatis:	() Y () N
Asthma:	() Y () N	Epilepsy:	() Y () N	Pneumonia:	() Y () N
Atrial Fibrillation:	() Y () N	Fractures:	() Y () N	Hiatal Hernia/Reflux:	() Y () N
Bladder Infection:	() Y () N	Glaucoma:	() Y () N	Sinus Problems:	() Y () N
Bronchitis:	() Y () N	Gout:	() Y () N	Sleep Apnea:	() Y () N
Cancer:	() Y () N	Heart Attack:	() Y () N	Stomach Ulcers:	() Y () N
Cellulitis:	() Y () N	Heart Arrhythmia:	() Y () N	Stroke:	() Y () N
Congestive Heart Failure:	() Y () N	Heart Valve Disease:	() Y () N	Thyroid Disorders:	() Y () N
Coronary Artery Disease:	() Y () N	High Blood Pressure:	() Y () N	TIA:	() Y () N
Depression:	() Y () N	HIV:	() Y () N	Blood clots:	() Y () N
Diabetes:	() Y () N	Kidney Disease:	() Y () N	Osteoarthritis:	() Y () N
Dialysis:	() Y () N	Kidney Stones:	() Y () N	Rheumatoid Arthritis:	() Y () N
Diverticulitis:	() Y () N	Leukemia:	() Y () N	Osteoporosis:	() Y () N

Other: _____

Past Surgical History: Please mark all previous surgeries: () **None**

() C-section () Cataract surgery () Hernia repair () Hysterectomy () Pacemaker () Tonsils () Gall bladder
() TURP () Appendectomy () Arthroscopy () Thyroid () Mastectomy () Hip pinning () Cosmetic surgery
() Right total knee replacement () Left total knee replacement () Repeat Right knee replacement () Repeat
Left knee replacement () Right partial knee replacement () Left partial knee replacement
() Right total hip replacement () Left total hip replacement () Repeat Right hip replacement () Repeat Left hip
replacement
Other surgery: _____

Problems with anesthesia: () Yes () No explain: _____

Problems with Foley/Bladder catheter: () Yes () No explain: _____

Elaborate on medical history/medications if necessary (use separate sheet if necessary):

Primary Care Physician: (name, address and phone number) _____

Reviewed by Provider: _____ Date: _____