

Medical History

Date: _____

Name: _____ DOB: _____

Family Physician: _____ Location: _____ Phone: _____

Cardiologist: _____ Location: _____ Phone: _____

Other MDs _____ Location: _____ Phone: _____

Referring Physician: _____

RN ONLY

HT	BP	RHD
WT	P	LHD

Describe Problem that you are here for today: _____

Date of Injury or onset: _____

Please check below if you have any if the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Diabetes: Non Insulin Dep | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Diabetes: Insulin Dep | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> COPD/Emphysema |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Thyroid Overactive |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Kidney Dialysis | <input type="checkbox"/> Thyroid Underactive |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Frequent Urinary Tract Infections | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Additional Active Medical Problems | | |

<u>Surgeries:</u>	Date	MD	Complications

Allergies:

Medication Allergy: _____

Latex Allergy: _____

Other Allergies: _____

Difficulty with Anesthesia: _____

Medical History

Date: _____

Name: _____ DOB: _____

Medications:

Dosage:

Frequency:

	Dosage:	Frequency:

Social History

Marital Status : S M D W

Occupation:

Do you smoke? Yes ___ No ___ If yes, How many packs per day? _____

Did you ever smoke? Yes ___ No ___ If yes, when did you quit? _____

Alcohol use:

Recreational Drug use:

Family History

Heart Disease :

Cancer:

Diabetes:

Arthritis:

Stroke:

Spinal Disorders:

Osteoporosis:

Other:

Review of Systems

If you have had any of the following, please explain:

Ear Problems:

Visual Difficulties:

Nose/Throat Problems:

Heart/Circulatory Disease:

Lung/Breathing Difficulties:

Stomach/Intestinal Problems:

Neurological Hx:

Psychological Conditions:

Blood Disease: