

## YOUR MEDICAL HISTORY

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

AGE: \_\_\_\_\_ SEX: M / F HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

WORK STATUS:

OCCUPATION: \_\_\_\_\_

Full Time  Part Time  Not Employed

*Please read the following instructions carefully.*

Last Date Worked: \_\_\_\_/\_\_\_\_/\_\_\_\_

### PAST MEDICAL HISTORY

Listed below are several different medical problems. Please make a **mark** in the box for *all that apply* to you.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Angina                  | <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> Nerve Problems   |
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Heart Disease/ Problems | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Bowel/ Bladder Problems | <input type="checkbox"/> Hernia                  | <input type="checkbox"/> Strokes          |
| <input type="checkbox"/> Breast Problems         | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Other: _____     |
| <input type="checkbox"/> Gout                    | <input type="checkbox"/> Liver Problems          |   |

### PAST SURGICAL HISTORY

Listed below are several different types of surgeries. Please make a **mark** in the box for *all that apply* to you.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Angioplasty                  | <input type="checkbox"/> Hernia                        | <input type="checkbox"/> Spinal Fusions                |
| <input type="checkbox"/> Appendectomy                 | <input type="checkbox"/> Hysterectomy (uterus removed) | <input type="checkbox"/> Thyroid                       |
| <input type="checkbox"/> Arthroscopy of knee/shoulder | <input type="checkbox"/> Oophorectomy (ovary removed)  | <input type="checkbox"/> Tonsils/ Adenoids             |
| <input type="checkbox"/> Colon                        | <input type="checkbox"/> Open Heart                    | <input type="checkbox"/> Total Joint Replacement _____ |
| <input type="checkbox"/> Gall Bladder                 | <input type="checkbox"/> ORIF _____                    | <input type="checkbox"/> Tubal Ligation                |
|   |  | <input type="checkbox"/> Other: _____                  |

### MEDICATIONS

Please **mark** the following boxes for problems in which you are *currently* taking medication.

(Please mark *all that apply*)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Angina                  | <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> Liver Problems   |
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Heart Disease/ Problems | <input type="checkbox"/> Nerve Problems   |
| <input type="checkbox"/> Bowel/ Bladder Problems | <input type="checkbox"/> Hernia                  | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Breast Problems         | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Strokes          |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Ulcers           |
|  |  | <input type="checkbox"/> Other: _____     |

### SOCIAL HISTORY

Do you smoke? Yes or No (circle one) Average alcoholic drinks per week? \_\_\_\_\_

If yes, \_\_\_\_\_ packs/day.

### PAST FAMILY MEDICAL HISTORY

Listed below are several different medical problems. Please make a **mark** in the box for *all that apply* to a **member of your family**.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Angina                  | <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> Liver Problems   |
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Heart Disease/ Problems | <input type="checkbox"/> Nerve Problems   |
| <input type="checkbox"/> Bowel/ Bladder Problems | <input type="checkbox"/> Hernia                  | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Breast Problems         | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Strokes          |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Ulcers           |
|  |  | <input type="checkbox"/> Other: _____     |

**(SEE REVERSE SIDE)**

LISTED BELOW ARE SEVERAL TYPES OF SYMPTOMS/ PROBLEMS..

PLEASE CHECK THE: **CIRCLE IF YOU CURRENTLY HAVE THIS PROBLEM**  
**OR CHECK THE BOX IF YOU HAVE HAD THIS PROBLEM IN THE PAST**

**SYMPTOM/ PROBLEM**

**HEAD/ EARS/ EYES/  
NOSE/ THROAT**

- Headache
- Migraines
- Dizziness
- Vertigo
- Seizures or Epilepsy
- Glaucoma
- Blurred or Double vision
- Ringing in ears
- Deafness
- Chronic Sinus problems
- Nose Bleeds
- Runny Nose
- Difficulty Swallowing
- Hoarsness
- Goiter

**URINARY**

- Pain with Urination
- Blood with Urination
- Loss of Urine Control
- Multiple Urinary Tract Infs.
- Kidney Stones
- Prostate Enlargement

**CARDIOVASCULAR**

- Chest Pain
- Fast or Irregular Heart Beat
- Murmur
- High Blood Pressure
- Heart Attack
- Leg Swelling
- Blood Clot/ Phlebitis
- Blood Transfusions
- Shortness of Breath w/ exercise

**RESPIRATORY**

- Shortness of Breath lying in bed
- Coughing
- Wheezing
- Asthma
- Cough up Blood
- Night Sweating
- Pneumonia
- Tuberculosis

**INTEGUMENTARY**

- Skin Changes
- Skin Cancer
- Bruising

**ENDOCRINE**

- Excessive Hunger
- Excessive Thirst
- Frequent Urination
- Thyroid Problems
- Diabetes (Sugar Problems)
- Fatigue
- Temperature Sensitivity

**GASTROINTESTINAL**

- Recent Weight Gain or Loss
- Nausea
- Vomiting
- Vomiting Blood
- Diarrhea
- Constipation
- Jaundice (Yellow Skin)

**MUSCLE**

- Muscle Pain
- Joint Stiffness
- Weakness
- Tremors/ Shakes
- Arthritis

**NEUROLOGICAL**

- Memory Change
- Loss of Memory
- Fainting Spells
- Incoordination

**PSYCHOLOGICAL**

- Nervousness
- Anxiety
- Depression
- Hallucinations

**HEMATOLOGY**

- Unexplained Swelling
- Anemia
- Bleeding Problems

**IMMUNOLOGY**

- Environmental Allergies
- Seasonal Allergies
- Tobacco Use
- Alcohol Use

*To be completed by the medical staff...*

AGE: \_\_\_\_\_ WORK STATUS: \_\_\_\_\_

MEDICAL PHYSICIAN: \_\_\_\_\_

CONSULT REQUESTED BY: \_\_\_\_\_

HISTORY OF PROBLEM: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PRIOR TREATMENT: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(SEE REVERSE SIDE)