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 instuctions 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.

❑ Angina
❑ Allergies
❑ Bowel/ Bladder Problems
❑ Breast Problems
❑ Cancer
❑ Diabetes
❑ Gout
❑ Heart Attack
❑ Heart Disease/ Problems
❑ Hernia
❑ High Blood Pressure
❑ High Cholesterol
❑ Kidney Problems
❑ Liver Problems
❑ Nerve Problems
❑ Seizures
❑ Strokes
❑ Thyroid Problems
❑ Ulcers
❑ Other: ______________________

PAST SURGICAL HISTORY

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

❑ Angioplasty
❑ Appendectomy
❑ Arthroscopy of knee/shoulder
❑ Colon
❑ Gall Bladder
❑ Hernia
❑ Hysterectomy (uterus removed)
❑ Oophorectomy (ovary removed)
❑ Open Heart
❑ ORIF ______________
❑ Spinal Fusions
❑ Thyroid
❑ Tonsils/ Adenoids
❑ Total Joint Replacement __________
❑ Tubal Ligation
❑ Other: ______________________

MEDICATIONS

Please **mark** the following boxes for problems in which you are *currently* taking medication.
(Please mark *all that apply*)

❑ Angina
❑ Allergies
❑ Bowel/ Bladder Problems
❑ Breast Problems
❑ Cancer
❑ Diabetes
❑ Heart Attack
❑ Heart Disease/ Problems
❑ Hernia
❑ High Blood Pressure
❑ High Cholesterol
❑ Kidney Problems
❑ Liver Problems
❑ Nerve Problems
❑ Seizures
❑ Strokes
❑ Thyroid Problems
❑ Ulcers
❑ 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**.

❑ Angina
❑ Allergies
❑ Bowel/ Bladder Problems
❑ Breast Problems
❑ Cancer
❑ Diabetes
❑ Heart Attack
❑ Heart Disease/ Problems
❑ Hernia
❑ High Blood Pressure
❑ High Cholesterol
❑ Kidney Problems
❑ Liver Problems
❑ Nerve Problems
❑ Seizures
❑ Strokes
❑ Thyroid Problems
❑ Ulcers
❑ 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
- O ❑ Headache
- O ❑ Migraines
- O ❑ Dizziness
- O ❑ Vertigo
- O ❑ Seizures or Epilepsy
- O ❑ Glaucoma
- O ❑ Blurred or Double vision
- O ❑ Ringing in ears
- O ❑ Deafness
- O ❑ Chronic Sinus problems
- O ❑ Nose Bleeds
- O ❑ Runny Nose
- O ❑ Difficulty Swallowing
- O ❑ Hoarsness
- O ❑ Goiter

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

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

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

INTEGUMENTARY
- O ❑ Skin Changes
- O ❑ Skin Cancer
- O ❑ Bruising

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

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

MUSCLE
- O ❑ Muscle Pain
- O ❑ Joint Stiffness
- O ❑ Weakness
- O ❑ Tremors/ Shakes
- O ❑ Arthritis

NEUROLOGICAL
- O ❑ Memory Change
- O ❑ Loss of Memory
- O ❑ Fainting Spells
- O ❑ Incoordination

PSYCHOLOGICAL
- O ❑ Nervousness
- O ❑ Anxiety
- O ❑ Depression
- O ❑ Hallucinations

HEMATOLOGY
- O ❑ Unexplained Swelling
- O ❑ Anemia
- O ❑ Bleeding Problems

IMMUNOLOGY
- O ❑ Environmental Allergies
- O ❑ Seasonal Allergies
- O ❑ Tobacco Use
- O ❑ Alcohol Use

To be completed by the medical staff…

T: ____________ **PULSE:** ________________ **BP:** _________________ **AGE:** _____________ **WORK STATUS:**____________________

MEDICAL PROVIDER: ___________________________________ **REFERRING PROVIDER:** ________________________________

SPECIALIST: ____ **CASE MANAGER:** _____________________________________

HISTORY OF PROBLEM: ____

____

____

____

____

____

____

____

PRIOR TREATMENT: ____

ALLERGIES: ____

MEDICATIONS: ❑ **SEE MEDICATION HISTORY SHEET**

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

(SEE REVERSE SIDE)