# Medical History Form

Name_____

Date of Birth _____

**General:**

What activities and hobbies do you participate in on a regular basis? _____ _____

_____ _____ _____ _____

Who is your primary care provider (PCP)? _____

Do you have regular wellness checks? ❑ Yes ❑ No How often? _____

Have you ever had other work-related injuries? ❑ Yes ❑ No

Please list any reasons for which you have had surgery and/or gone to the hospital (give dates)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Have you ever had injuries to the following areas?

Neck ❑ Yes ❑ No Back ❑ Yes ❑ No

Knees ❑ Yes ❑ No Shoulders ❑ Yes ❑ No

**Medications:**

List all medications you are taking: _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Herbal / naturopathic treatment and/or medications: _____

_____ _____ _____ _____

Any allergic reactions to medication? ❑ Yes ❑ No List: _____

_____

**Social history and habits:**

Do you use tobacco? ❑ Yes ❑ No

If yes, ❑ Smoke ❑ Chew ❑ Plan to stop Number of years smoked _____ Packs per day _____

If no, ❑ Never used ❑ Quit in _____

Do you drink alcoholic beverages? ❑ Yes ❑ No

❑ Regularly (3+ times a week) ❑ Seldom /Occasionally

Do you use illegal or unprescribed medications? ❑ Yes ❑ No

Do you have a history of drug abuse or addiction? ❑ Yes ❑ No

Have you ever received treatment for drug/alcohol abuse? ❑ Yes ❑ No

| Family History: Mark corresponding box for any family members with the following conditions. | Grand father | Grand mother | Father | Mother | Sibling | Child |
|---|---|---|---|---|---|---|
| Diabetes | | | | | | |
| High Blood Pressure | | | | | | |
| Heart Attack | | | | | | |
| Stroke | | | | | | |
| Epilepsy/Seizures | | | | | | |
| Tuberculosis | | | | | | |
| Cancer | | | | | | |
| Alcoholism/Drug abuse/Addiction | | | | | | |
| Depression | | | | | | |
| Other Mental Health Issues | | | | | | |

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| SYSTEMS: Have you had the following issues? | No | Yes | For how long/ how long ago? | Explain |
|---|---|---|---|---|
| **GENERAL** | | | | |
| Unexplained weight loss/gain | | | | |
| Fever/fatigue | | | | |
| Head injury/Traumatic brain injury | | | | |
| List all cancers for which you have been diagnosed and/or treated (e.g., Lung, stomach/bowel, breast, cervical, prostate, etc.) | | | | |
| | | | | |
| | | | | |
| **EYES** | | | | |
| Color blindness | | | | |
| Continuous blurring of vision | | | | |
| Double vision | | | | |
| Glasses/contacts | | | | |
| Other eye problems (specify) | | | | |
| **EARS** | | | | |
| Hearing Loss | | | | |
| Continuous ringing in ears | | | | |
| Other ear problems (specify) | | | | |
| **NOSE/THROAT** | | | | |
| Hay fever | | | | |
| Sinus troubles | | | | |
| Sleep disorder (e.g., sleep apnea) | | | | |
| Other problems (explain) | | | | |
| Nose | | | | |
| Throat | | | | |
| Neck | | | | |
| **LUNGS/CHEST** | | | | |
| Continuous nagging cough/hoarseness | | | | |
| Coughed up blood | | | | |
| Wheezing | | | | |
| Shortness of breath | | | | |
| Asthma | | | | |
| Pneumonia | | | | |
| COPD | | | | |
| Obstructive sleep apnea (Sleep disorder) | | | | |
| Tuberculosis (TB) | | | | |
| Scarring on chest x-ray | | | | |
| **HEART/BLOOD VESSELS** | | | | |
| Ankle swelling | | | | |
| Chest pain | | | | |
| Atrial fibrillation | | | | |
| Irregular heart beat | | | | |

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| HEART/BLOOD VESSELS | No | Yes | For how long/ how long ago? | Explain |
|---|---|---|---|---|
| Heart attack | | | | |
| Heart murmur | | | | |
| High blood Pressure | | | | |
| Stroke | | | | |
| Elevated cholesterol | | | | |
| Other heart or blood vessel problems (specify) | | | | |
| HEMATOLOGY | | | | |
| Hemophilia or bleeding disorder | | | | |
| Clotting disorder | | | | |
| Other blood dyscrasias (specify) | | | | |
| GASTROINTESTINAL | | | | |
| Difficulty swallowing or indigestion | | | | |
| Unusual heartburn | | | | |
| Vomited blood | | | | |
| Change in bowel habits | | | | |
| Cirrhosis | | | | |
| Hepatitis (Yellow Jaundice) | | | | |
| Gallbladder disease | | | | |
| Ulcers | | | | |
| Pancreatitis | | | | |
| Colitis | | | | |
| Diverticulosis | | | | |
| Hemorrhoids | | | | |
| Hernia | | | | |
| Other GI problems (specify) | | | | |
| URINARY | | | | |
| Frequent Urination | | | | |
| Getting up at night to urinate | | | | |
| Kidney infections | | | | |
| Kidney stones | | | | |
| Bladder infections | | | | |
| BONE/MUSCLE | | | | |
| Joint aches | | | | |
| Joint stiffness | | | | |
| Fractures (Specify where) | | | | |
| Chronic back pain | | | | |
| Back disc disease | | | | |
| Fibromyalgia | | | | |
| Arthritis | | | | |
| Other bone/muscle problems (specify) | | | | |

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| NERVOUS SYSTEM | No | Yes | For how long/ how long ago? | Explain |
|---|---|---|---|---|
| Headaches | | | | |
| Seizures/epilepsy | | | | |
| Other nervous system problems (specify) | | | | |
| **ENDOCRINE/GLANDULAR DISORDERS** | | | | |
| Thyroid problems | | | | |
| Diabetes (circle responses below) | | | | |
| Type 1 Type 2 controlled by: diet/exercise alone oral medication insulin injections | | | | |
| Other endocrine problems (specify) | | | | |
| Other immunosuppressive condition (specify) | | | | |
| **SKIN** | | | | |
| Lump or unusual thickening of skin | | | | |
| Sore that does not heal | | | | |
| Obvious change in wart or mole | | | | |
| Other skin problem (specify) | | | | |
| **PSYCHOLOGICAL** | | | | |
| Anxiety disorder | | | | |
| Depression | | | | |
| Bipolar | | | | |
| Schizophrenia | | | | |
| Insomnia/sleep disturbance | | | | |
| Other psychological issue (specify) | | | | |
| **MEN ONLY** | | | | |
| Prostate infection | | | | |
| Prostate enlargement | | | | |
| Testicle problem | | | | |
| Other genital problems | | | | |
| **WOMEN ONLY** | | | | |
| Breast issues (lumps, etc.) | | | | Date of last mammogram: |
| Uterus problems (e.g., Hysterectomy) | | | | |
| Unusual bleeding or discharge | | | | |
| Still having regular periods? | | | | Date of last period: |
| Do you think you may be pregnant? | | | | |
| Have you ever been pregnant? | | | #Pregnancies: | #Live births: |

Patient Signature _____ Provider Signature _____ Date_____