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COMPREHENSIVE MEDICAL HISTORY

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We apologize for the inconvenience, but due to new insurance and governmental regulations, all physicians are required to ask you **extensive medical history**. Your doctor is likely to ask you about some of these again.

Name: _____ Date:_____

Date of birth: _____ Age:_____

Weight: _____ Height:_____

Who referred you to this office? _____

Who is your family physician or medical doctor?

_____

Reason for visit? _____

_____

Date of injury or onset?_____

Did this happen on the job? ❑ Yes ❑ No

Were you involved in an automobile accident? ❑ Yes ❑ No

If this is an accident, WHERE and HOW did this accident occur? _____

_____

_____

Have you been treated for **this problem** by anyone else? If Yes:

WHERE_____

BY WHOM _____

Are you presently on any medication for **this problem**?

DRUG	DOSE
_____	_____
_____	_____
_____	_____

Have you had XRAYS, MRI, or other studies? ❑ Yes ❑ No

If Yes, where and when?

Study	Location	Date
_____		
_____		
_____		

Are you pregnant? ❑ Yes ❑ No

Have you, or any member of your family been seen in this office before?

❑ Yes ❑ No

If Yes, whom:_____

ALLERGIES / DRUG REACTIONS:

❑ No Known Allergies

Food / Drug / Substance	Type of Reaction
_____	_____
_____	_____
_____	_____

Preferred Pharmacy: _____
(name, location, number)

Email Address:_____

Contact Preference: Mobile:_____ Work_____

Home:_____

DEMOGRAPHIC DATA:

Languages Spoken: _____

Racial Category:

[ ] American Indian or Alaska Native
[ ] Native Hawaiian or Pacific Islander
[ ] Asian [ ] White [ ] Mixed
[ ] Black or African American

Ethnicity:

[ ] Latino or Hispanic (culture, regardless of race)
[ ] Non-Latino or Non-Hispanic

MEDICATIONS: You are now taking, including: Non-Prescription, Aspirin, Birth Control Pills/Vitamins/Supplements/Herbal Remedies:

Drug / Dosage / Route

_____
_____
_____
_____
_____
_____
_____

❑ List additional medications on back.

PREVIOUS HOSPITALIZATIONS/OPERATIONS

Date	Reason
_____	_____
_____	_____
_____	_____

❑ List additional surgeries on back.

REVIEW OF SYSTEMS

VI. Do you have any of the following:

CONSTITUTIONAL	NO	YES	If Yes, Describe
Fever/Night sweats			
Weight Loss/Gain > 6 lb.			
Exercise intolerance			
Fatigue			
Hepatitis:			
HIV/AIDS			
Blood clot			
Bleeding disorder			
Blood thinners			
MSRA Inection			

EENT	NO	YES	If Yes, Describe
Eyes: Dry eyes			
Irritation			
Dizziness			
Ears: Hearing problem			
Ear pain			
Ringing			
Nose: Nosebleeds			
Sinus/nose problems			
Throat/Mouth:			
Sore throat			
Bleeding gums			
Snoring			
Swallowing problems			

Other Problems:

CARDIOVASCULAR	NO	YES	If Yes, Describe
Chest pain/angina			
Pain with exertion			
Short of breath-walking			
Short of breath-lying down			
Heart murmur/Palpitations			
Edema-lower extremities			

Other Problems:

RESPIRATORY	NO	YES	If Yes, Describe
Cough, wheeze			
Short of breath			
Cough blood			
Sleep apnea			

Other Problems:

GASTROINTESTINAL	NO	YES	If Yes, Describe
Abdominal pain			
Vomiting			
Appetite changes			
Diarrhea			
Bloody stool			

Other Problems:

GENITOURINARY	NO	YES	If Yes, Describe
Incontinence			
Difficulty with urination			
Hematuria			
Increased frequency			

Other Problems:

GYNECOLOGICAL	NO	YES	If Yes, Describe
Vaginal bleeding			
Abnormal menses			
Vaginal drainage			
Breast mass			
Breast drainage			
Pregnant or missed period			

Other Problems:

MUSCULOSKELETAL	NO	YES	If Yes, Describe
Muscle aches			
Weakness			
Joint pain			
Swelling extremities			
Back pain			

Other Problems:

SKIN	NO	YES	If Yes, Describe
Abnormal mole			
Jaundice			
Rashes			

Other Problems:

NEUROLOGIC	NO	YES	If Yes, Describe
Loss consciousness			
Weakness			
Numbness			
Seizures			
Dizziness			
Headache			

Other Problems:

VI. Have you ever had, or do you have any of the following:

PSYCHIATRIC	NO	YES	If Yes, Describe
Depression			
Sleep disturbances			
Alcohol abuse			
Psychiatric medication use			
Anxiety			

Other Problems:

ENDOCRINE	NO	YES	If Yes, Describe
Fatigue			
Increase thirst			
Increased hair loss			
Increased hair growth			
Cold intolerance			
Steroid use			

Other Problems:

HEMATOLOGIC/ LYMPHATIC	NO	YES	If Yes, Describe
Swollen glands or nodes			
Bruising			
Bleeding problems			
Blood thinners			

Other Problems:

ALLERGY/ IMMUNOLOGY	NO	YES	If Yes, Describe
Runny nose			
Sinus pressure			
Itching			
Hives			
Sneezing			

Other Problems:

FAMILY HISTORY	NO	YES	If Yes, Describe
Arthritis			
Hypertension			
Heart Disease			
Diabetes			
Other			

Siblings:	Dead	Alive	Cause of Death
Parents:			
Mother			
Father			

SOCIAL HISTORY

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Children: ❑ Yes ❑ No Ages_____

Smoking Status: Do you smoke now? ❑ Yes ❑ No

Have you ever smoked? ❑ Yes ❑ No No. of Years _____

Alcohol Intake: Type_____ Amount_____

Illicit/Recreational Drug Use: _____

Exercise Level: ❑ None ❑ Occasional ❑ Moderate ❑ Heavy

PAST MEDICAL HISTORY	NO	YES	If Yes, Describe
Anesthesia Complications			
Anemia			
Anxiety/Panic Disorder			
Arrhythmia/ A-fib			
Arthritis			
Asthma			
Bipolar Disorder			
Bleeding Disorder			
Blood clots/DVT			
Bronchitis/Emphysema			
Cancer/Tumors			
Chest Pain/Angina			
Congestive Heart Failure			
Coronary Artery Disease			
Diabetes			
Fainting/Syncope			
Fractures			
Gastrointestinal Ulcers			
Gerd/Reflux			
Gout			
Glasses			
Heart Attack/MI			
Hepatitis			
HIV AIDS			
Hypertension/high blood pressure			
High Cholesterol			
Joint Replacement			
Kidney Disease/Dialysis			
Leg/foot Ulcers			
Liver Disease			
Lyme's Disease			
MSRA Infection			
Migraines/headaches			
Neuromuscular disease			
Osteoporosis			
Pacemaker			
Peripheral Vascular Disease			
Prostate Disease			
Pulmonary Embolism			
Reflex Sympathetic Dystrophy			
Rheumatoid Arthritis			
Seizures/Epilepsy			
Sexually Transmitted Diseases			
Stroke			
Thyroid Problems			
Tuberculosis			
Ulcers- Extremity/Skin			