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Medical History

Patient Name: ______________________________ Date of Birth: ______________

Age: ________ Height: __________ Weight: ________ **Staff Only** BMI: ________ BP: ____________

Primary Care Physician: ______________________ Referring Physician: ______________________

Reason for today's visit: ____

Symptoms (specific problems): ______________________________________

How long have you had symptoms?: __________________________________

Is your current problem a result of an accident? ☐ Yes ☐ No If yes, Date: ______________

If yes, check ALL that apply:

☐ Car Accident ☐ Work Accident ☐ Other accident: ______________

Social History

Occupation: ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have any children? ☐ Yes ☐ No If yes, how many? ______________________

Do you live alone? ☐ Yes ☐ No If no, who lives with you? ______________________

Do you smoke? ☐ Yes, I smoke ______ packs of cigarettes per day for ______ years. ☐ No, I have never smoked.

☐ No, I quit ______ years ago. At the time, I smoked ______ packs of cigarettes per day for ______ years.

Do you drink alcohol? ☐ No ☐ No, but I used to ☐ Yes

How often did you have a drink containing alcohol in the past year? ☐ once a month or ______ times per month

How many drinks did you have on a typical day when you were drinking in the past year? ______

How often did you have six or more drinks on one occasion in the past year? ____________

Are you at risk for AIDS (e.g. drug abuse, previous blood transfusion)? ☐ Yes ☐ No

If yes, please explain: ____

Family History

Family Member	Alive/Deceased	Age	Health Status/Cause of Death
Grandmother (Mother's)			
Grandfather (Mother's)			
Grandmother (Father's)			
Grandfather (Father's)			
Mother			
Father			
Sister/Brother			
Sister/Brother			

Past Medical Problems

Any major illnesses and/or injuries?

Hypertension ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Kidney Disease ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
Blood Clotting ☐ Yes ☐ No
Heart Disease ☐ Yes ☐ No
Recent Infections ☐ Yes ☐ No
Other ______________________________________

Please list surgical history and/or hospitalizations.

Surgery/Hospitalization	Year	Complications

Have you ever had problems with anesthesia? ☐ Yes ☐ No

____

Current Medications (including over the counter medications)	Dose	Frequency

Allergies to Medications: ____

____

Spine problems:

Have you had a trial of anti-inflammatory or muscle relaxants? ☐ Yes ☐ No

If yes, what type? ____________________________ How long? ____________________________

Have you had physical therapy? ☐ Yes ☐ No If yes, how long? ____________________________

Have you had pain injections (e.g. epidural, facet or nerve block)? ☐ Yes ☐ No

If yes, when? ____________________________ How many? ____________________________

Which physician performed blocks? ____

Review of Systems

Have you ever had or are you currently having problems with any of the following?

Constitutional:

Fever	☐ Yes	☐ No
Weight Loss	☐ Yes	☐ No
Excessive Fatigue	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No

Eyes:

Do you wear glasses?	☐ Yes	☐ No	If yes, when was your last exam? ______________________
Infections	☐ Yes	☐ No	
Injuries	☐ Yes	☐ No	
Glaucoma	☐ Yes	☐ No	
Cataracts	☐ Yes	☐ No	

Ear, Nose, Throat and Mouth:

Hearing Loss	☐ Yes	☐ No	If you wear hearing aids, when was your last exam? ______
Ear Pain	☐ Yes	☐ No	
Ear Infections	☐ Yes	☐ No	
Ringing in Ears	☐ Yes	☐ No	If yes, please circle one: Left Right Both Not applicable
Balance Disturbance (e.g. Vertigo, Spinning)	☐ Yes	☐ No	
Nosebleeds	☐ Yes	☐ No	
Nasal Congestion	☐ Yes	☐ No	
Nasal Drainage	☐ Yes	☐ No	
Inability to Smell	☐ Yes	☐ No	
Sinus Problems	☐ Yes	☐ No	
Sinus Headache	☐ Yes	☐ No	
Sore Throats	☐ Yes	☐ No	
Mouth Sores	☐ Yes	☐ No	

Cardiovascular:

Chest Pain/Angina	☐ Yes	☐ No	If yes, when was your last EKG? ____________________
High Blood Pressure	☐ Yes	☐ No	
Irregular Pulse	☐ Yes	☐ No	
Heart Murmur	☐ Yes	☐ No	
High Cholesterol	☐ Yes	☐ No	
Swelling in Feet/Hands	☐ Yes	☐ No	
Leg Pain while walking	☐ Yes	☐ No	

Respiratory:

Asthma	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Lung Cancer	☐ Yes	☐ No
Bloody Sputum	☐ Yes	☐ No

When was your last Chest x-ray: ______________________

Review of Systems (cont.)

Have you ever had or are you currently having problems with any of the following?

Gastrointestinal:

Indigestion/Pain Eating	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Blood in Vomit	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Abdominal Pain	☐ Yes	☐ No
Change in Bowel	☐ Yes	☐ No
Ulcers or Gastritis	☐ Yes	☐ No
Colon Cancer	☐ Yes	☐ No

Genitourinary:

Urinary Tract Infection	☐ Yes	☐ No
Painful Urination	☐ Yes	☐ No
Blood in Urine	☐ Yes	☐ No
Difficulty/Incontinence	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No
Prostate Cancer (male)	☐ Yes	☐ No
Endometriosis (female)	☐ Yes	☐ No
Uterine/Cervical Cancer	☐ Yes	☐ No

Musculoskeletal:

Arm/Leg Weakness	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No
Arm/Leg Pain	☐ Yes	☐ No
Joint Pain or Swelling	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No

Please list any broken bones ____

Integumentary:

Skin Disease	☐ Yes	☐ No
Skin Cancer	☐ Yes	☐ No
Breast Pain/swelling	☐ Yes	☐ No
Nipple Discharge	☐ Yes	☐ No

When was your last mammogram? ______________________

Neurological:

Fainting/Black Outs	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Memory Problems	☐ Yes	☐ No
Disorientation	☐ Yes	☐ No
Trouble with Speech	☐ Yes	☐ No
Inability to Concentrate	☐ Yes	☐ No
Double/Blurred Vision	☐ Yes	☐ No
Facial Weakness	☐ Yes	☐ No
Coordination problems in arms/legs	☐ Yes	☐ No

Review of Systems (cont.)

Have you ever had or are you currently having problems with any of the following?

Psychiatric:

Anxiety	☐ Yes	☐ No	
Depression	☐ Yes	☐ No	
Other Psychiatric Disorder	☐ Yes	☐ No	If yes, please list ______________________

Endocrine:

Diabetes	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Increase in Appetite	☐ Yes	☐ No
Hormone Problems	☐ Yes	☐ No
Excessive Thirst or Urination	☐ Yes	☐ No

Hematologic/Lymphatic:

Anemia	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Bleeding Tendencies	☐ Yes	☐ No
Swollen Glands or Lymph Nodes	☐ Yes	☐ No

Allergic/Immunologic:

Food Allergies	☐ Yes	☐ No
Nasal/Inhalant Allergy	☐ Yes	☐ No
Immunologic Disorder	☐ Yes	☐ No

The above information is accurate to the best of my knowledge.

Patient's Signature: ______________________________ **Date:** ________________