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Medical History Update

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 ____________________

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? ____________________

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 recent surgeries and/or hospitalizations.

Surgery/Hospitalization	Year	Complications

Please list current medications or provide a copy of your medication list.

Current Medications	Dose	Frequency

Allergies to Medications: ____

Patient Signature: ____ Date: ____________________