

Patient: \_\_\_\_\_ Age \_\_\_\_\_ DOB: \_\_\_\_\_ M / F

PATIENT MEDICAL HISTORY

Date: \_\_\_\_\_

Handedness R / L

REASON FOR SEEING THE DOCTOR TODAY: \_\_\_\_\_

**Review of Systems:**

IN THE PAST TWO WEEKS HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS? (If yes, please explain)

Symptom:	Explanation:
FEVER, CHILLS, WEIGHT LOSS	(YES / NO) _____
CHANGES IN YOUR VISION	(YES / NO) _____
CHANGES IN YOUR HEARING	(YES / NO) _____
CHEST PAIN	(YES / NO) _____
BREATHING DIFFICULTIES	(YES / NO) _____
NAUSEA, VOMITING	(YES / NO) _____
BOWEL CHANGES	(YES / NO) _____
CHANGES IN URINATION	(YES / NO) _____
SKIN SORES /DISCOLORATION	(YES / NO) _____
BRUISING OR BLEEDING	(YES / NO) _____
UNUSUAL ILLNESSES	(YES / NO) _____
OTHER PROBLEMS?	(YES / NO) _____

**Past Medical History**

HAVE YOU HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?

HIGH BLOOD PRESSURE (YES / NO)	DIABETES (YES / NO)
HEART ATTACK (YES / NO) When? _____	HEART DISEASE (YES / NO)
CANCER (YES / NO) Type? _____	ULCERS (YES / NO)
STROKE (YES / NO) When? _____	ASTHMA (YES / NO)
LUNG PROMBLEMS (YES / NO)	BLOOD CLOTS (YES / NO)

DO YOU HAVE ANY OTHER MEDICAL PROBLEMS? (YES / NO) If yes, please explain:

PLEASE LIST ANY **MEDICATIONS** YOU ARE CURRENTLY TAKING? (Please circle if NONE)

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**PATIENT MEDICAL HISTORY**

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PLEASE LIST ANY **SURGERIES** YOU HAVE HAD IN THE PAST? (Please circle if NONE)

\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ANY **DRUG ALLERGIES** (please circle if NONE) \_\_\_\_\_

\_\_\_\_\_

**Family History:** PLEASE LIST ANY HEALTH PROBLEMS IN YOUR FAMILY:

FATHER: \_\_\_\_\_

MOTHER: \_\_\_\_\_

OTHER: \_\_\_\_\_

**Social History:**

DO YOU SMOKE NOW? (YES / NO) IF YES, HOW MUCH? \_\_\_\_\_ HOW LONG? \_\_\_\_\_

HAVE YOU SMOKED IN THE PAST? (YES / NO) WHEN DID YOU QUIT? \_\_\_\_\_

DO YOU DRINK ALCOHOL? (YES / NO) HOW MUCH? \_\_\_\_\_

DO YOU USE RECREATIONAL DRUGS (YES / NO) \_\_\_\_\_

WHAT IS YOUR OCCUPATION? \_\_\_\_\_

WHAT IS YOUR HEIGHT? \_\_\_\_\_ WEIGHT? \_\_\_\_\_

IS THIS INJURY WORK RELATED? (YES / NO) IF YES, PLEASE EXPLAIN: \_\_\_\_\_

\_\_\_\_\_

EMPLOYER: \_\_\_\_\_

WORKMAN COMPENSATION COMPANY: \_\_\_\_\_

ADJUSTOR: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

\_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_

IS THIS RELATED TO AN AUTOMOBILE ACCIDENT? (YES / NO) IF YES, PLEASE EXPLAIN

\_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_ INSURANCE: \_\_\_\_\_

ATTORNEY NAME & ADDRESS: (if applicable): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_