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PATIENT MEDICAL HISTORY

Please answer all questions - Print All Information. If uncertain, use a question mark (?)

NAME LAST, FIRST, MIDDLE	E-MAIL	BIRTHDATE	AGE	BIRTH PLACE	TODAY'S DATE

OCCUPATION	EMPLOYED BY	MARITAL STATUS S M D W	HEIGHT	WEIGHT

REASON YOU ARE BEING SEEN HERE?	IS THIS THE RESULT OF AN INJURY?	DATE OF INJURY

DID THIS INJURY HAPPEN AT WORK?	IS THIS INJURY RELATED TO A CAR ACCIDENT?	DATE OF ACCIDENT

HAVE YOU HAD PAIN SIMILAR TO THIS IN THE AFFECTED AREA PRIOR TO THE ACCIDENT/INJURY?	WHO REFERRED YOU TO OUR PRACTICE?

PAST HISTORY: *GIVE AGE AT ONSET OF ANY OF FOLLOWING ILLNESSES YOU HAVE HAD.*

Measles	Polio	Diabetes	Mononucleosis	Nervous Condition
German Measles	Bronchitis	Eczema	Liver Disease	Eye Trouble
Pneumonia	Hives	Hemorrhoids	Ear Trouble	Valley Fever
Emphysema	Ulcers	Hernia	Kidney Disease	High Blood Pressure
Asthma	Hay Fever	Thyroid Disease	Kidney Stones	Rheumatic Fever
Arthritis	Jaundice	Sexually Transmitted Disease	Tuberculosis	Heart Trouble

FEMALES:

Last menstrual period: _____ Cycle length: _____ Age mensus started:_____ stopped:_____

INJURIES: *LIST ALL SERIOUS INJURIES. INCLUDE BROKEN BONES, HEAD OR BACK INJURIES, AND DISLOCATIONS. GIVE YEAR OCCURRED*

1._____ 2._____ 3._____

4._____ 5._____ 6._____

SURGERY: *LIST ANY OPERATIONS NOT INCLUDED ABOVE.*

1._____ 2._____ 3._____

4._____ 5._____ 6._____

DO YOU USE TOBACCO NOW?_____ IN THE PAST?_____ TYPE_____ DAILY AMOUNT _____ HOW LONG?_____

DO YOU USE ALCOHOLIC BEVERAGES?_____ IN THE PAST?_____ TYPE_____ DAILY AMOUNT _____ HOW LONG?_____

MEDICATIONS: *LIST ALL MEDICATIONS THAT YOU TAKE REGULARLY OR FREQUENTLY. INCLUDE PRESCRIBED DRUGS, VITAMINS, ANTACIDS, BIRTH CONTROL PILLS, ETC., AND FREQUENCY OF USE.*

1._____ 2._____ 3._____

4._____ 5._____ 6._____

7._____ 8._____ 9._____

Please Continue on Back if Necessary

ALLERGIES: *LIST ALL KNOWN MEDICATION ALLERGIES, TYPE OF REACTION AND STOMACH TROUBLE.*

1._____ 2._____ 3._____

4._____ 5._____ 6._____

7._____ 8._____ 9._____

Please Continue on Back if Necessary

HOSPITALIZATIONS *(Do not list normal Pregnancies)*		**MONTH & YEAR**	**REASON FOR HOSPITALIZATION**
	1.		
	2.		
	3.		
	4.		
	5.		
	6.		

HAND DOMINANCE (Circle One) L R

IMMUNIZATIONS/DATE:

TETANUS_____ MEASLES_____ HEPATITIS B_____ PNEUMONIA_____ TB SKIN TEST_____

LIST DATES OF TEST:

_____ PAP SMEAR_____ ANY ABNORMAL_____

_____ _____

_____ _____

_____ _____

_____ _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION?_____ _____

HAVE YOU EVER BEEN TESTED FOR AIDS?_____ _____

FAMILY HISTORY RELATION	AGE	STATE OF HEALTH	IF DECEASED, CAUSE OF DEATH	AGE AT DEATH
FATHER				
MOTHER				
BROTHERS AND SISTERS				
SPOUSE				
CHILDREN				

CHECK IF ANY BLOOD RELATIVE OR SPOUSE EVER HAD:

ILLNESS	✓	RELATION	ILLNESS	✓	RELATION	ILLNESS	✓	RELATION
DIABETES			THYROID			TROUBLE ALLERGIES		
HIGH BLOOD PRESSURE			TUBERCULOSIS			ASTHMA		
HEART TROUBLE			EPILEPSY			ANEMIA		
STROKE			ARTHRITIS			GLAUCOMA		
CANCER/ WHAT ORGAN?			BLOOD DISEASE			STOMACH ULCERS		
KIDNEY TROUBLE			MENTAL ILLNESS			DUODENAL ULCERS		

ARE THERE OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS AT A FUTURE APPOINTMENT?