

Medical History

Name _____ Height _____ Weight _____ Age _____

Surgical History (List any surgeries within the past 10 years.)

Date	Type of Surgery	Complications	Doctor	Date	Type of Surgery	Complications	Doctor

Social History

- Do you smoke? Yes No How many years? _____ How many packs per day? _____
- If you have ever smoked, how many years did you smoke? _____ How many packs per day? _____ When did you quit? _____
- Do you drink? Yes No How frequently? _____

Reason for Today's Visit _____ R or L _____
Date of Injury/ Onset _____
How did injury occur? _____
Where did injury occur? _____ School _____ Work _____ Auto _____ Home _____ Other _____
Rate Pain 1-10 (1< 10>) _____ What makes it worse/better? _____
Have x-rays been taken? _____ When/Where? _____

Past Medical History (Have you ever been treated for the following?)

- Heart Problems..... Yes No
- Circulatory Problems..... Yes No
- Hypertension..... Yes No
- Hepatitis, jaundice, or liver disease Yes No
- Stomach ulcers..... Yes No
- Thyroid problems..... Yes No
- Stroke..... Yes No
- Asthma..... Yes No
- Cardiac pacemaker..... Yes No
- Arthritis Yes No
- Anemia..... Yes No
- Emphysema..... Yes No
- Seizures..... Yes No
- Cancer..... Yes No
- AIDS, HIV, immune system disorders..... Yes No
- Kidney problems..... Yes No
- Eye problems..... Yes No
- Gout..... Yes No
- Hearing problems..... Yes No
- Tuberculosis..... Yes No
- Coughing blood..... Yes No
- Depression..... Yes No
- Females only: Are you pregnant?..... Yes No

Are your menses regular?..... Yes No

- Do you have diabetes or sugar..... Yes No

If yes, please answer the following:

- Do you take insulin..... Yes No
- How long have you been diagnosed? _____

Patient Signature _____

Recreational Activities

List any activities that you participate in on a regular basis.

Family History

- Does any family member have diabetes? Yes No
- Does any family member have rheumatism? Yes No
- Does any family member have gout? Yes No
- Other: _____

List the drugs/medicines you are taking:

I am NOT taking any medications.

- _____ 6. _____
- _____ 7. _____
- _____ 8. _____
- _____ 9. _____
- _____ 10. _____

List the drugs/medicines you are ALLERGIC to:

I have NO drug allergies.

- _____ 5. _____
- _____ 6. _____
- _____ 7. _____
- _____ 8. _____