



**MEDICAL HISTORY FORM**

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Body Part Symptomatic: \_\_\_\_\_

Side of Body: Right Left Bilateral

Current Symptoms: Pain Swelling Stiffness Numbness Weakness Mass/lump Black/Blue  
 How long have you had these symptoms? \_\_\_\_\_

Please rate the severity of your symptoms: (1 minimal/ 10 severe) 1 2 3 4 5 6 7 8 9 10

<u>Review of Systems/Medical History</u>		
<b>Cardiovascular:</b>		
1. Irregular Heartbeat/palpitations	No	Yes, explain: _____
2. Heart Attack	No	Yes, explain: _____
3. Heart Disease	No	Yes, explain: _____
4. High Cholesterol	No	Yes, explain: _____
5. High Blood Pressure	No	Yes, explain: _____
6. Stroke	No	Yes, explain: _____
7. Leg Swelling ( L R Both )	No	Yes, explain: _____
<b>Respiratory:</b>		
1. Asthma	No	Yes, explain: _____
2. COPD/Emphysema	No	Yes, explain: _____
3. Shortness of Breath/Wheezing	No	Yes, explain: _____
<b>Hematologic/Oncology:</b>		
1. Cancer	No	Yes, explain: _____
2. Bleeding/Bruising	No	Yes, explain: _____
3. Blood Clot/DVT	No	Yes, explain: _____
<b>Skeletal:</b>		
1. Osteoarthritis	No	Yes, explain: _____
2. Rheumatoid Arthritis	No	Yes, explain: _____
<b>Integumentary:</b>		
1. Skin Disease	No	Yes, explain: _____
2. Open Wounds/Ulcers	No	Yes, explain: _____
<b>Endocrine:</b>		
1. Thyroid	No	Yes, explain: _____
2. Diabetes	No	Yes, explain: _____
<b>Renal:</b>		
1. Kidney	No	Yes, explain: _____
2. Prostate/BPH	No	Yes, explain: _____
<b>Nervous:</b>		
1. Seizures	No	Yes, explain: _____
2. Parkinson's Disease	No	Yes, explain: _____
<b>Digestive:</b>		
1. Irritable Bowel (IBS)	No	Yes, explain: _____
2. GERD (Reflux)	No	Yes, explain: _____
<b>Muscular:</b>		
1. Weakness	No	Yes, explain: _____
<b>Psychiatric:</b>		
1. Depression	No	Yes, explain: _____
2. Anxiety	No	Yes, explain: _____
Have you had a Dexa (Bone Density) Scan?	No	Yes When? _____

Reviewed by: \_\_\_\_\_

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

**Social History**

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Occupation/Retired: \_\_\_\_\_

Do you drink alcohol: No Socially Weekly Daily

Do You Smoke? No Yes \_\_\_\_\_ Packs/Day For \_\_\_\_\_ years Previous Smoker? \_\_\_\_\_ Duration: \_\_\_\_\_

Marital Status: \_\_Married \_\_Single \_\_Divorced \_\_Widowed

Living Conditions: \_\_Alone \_\_Spouse \_\_Family Member \_\_Assisted Living House Style: \_\_Ranch \_\_Multi-story/Stairs

Activities: Swimming Weights Aerobics Golf Tennis Other: \_\_\_\_\_

**Family History**

Have any of your family members had problems with:

Arthritis	No	Yes, explain: _____
Cancer	No	Yes, explain: _____
Diabetes	No	Yes, explain: _____
High Blood Pressure	No	Yes, explain: _____
Heart Disease	No	Yes, explain: _____
Other	No	Yes, explain: _____

Surgical Procedures: \_\_\_\_\_

Orthopaedic Procedures: \_\_\_\_\_

Are you currently taking any Medications? \_\_\_\_\_NO \_\_\_\_\_YES, please List: \_\_\_\_\_

**ALLERGIES:**

Do you have any drug allergies? \_\_\_\_\_NO \_\_\_\_\_YES, List & Reaction \_\_\_\_\_

**\*PREFERRED PHARMACY\***

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**\*MEDICAL DOCTOR\*:**

*Who is your*

Primary Medical Doctor? \_\_\_\_\_ Phone Number: \_\_\_\_\_

Cardiologist? \_\_\_\_\_ Phone Number: \_\_\_\_\_

Pulmonologist? \_\_\_\_\_ Phone Number: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date