

PATIENT MEDICAL HISTORY

Name: _____ Date: _____

Height: _____ Weight: _____ Birthplace: _____

Reason you are being seen here: Pain Disability Medication

Other: _____

Have you been seen here within the past 3 years? YES NO

Hand Dominance: Left Right

PAST MEDICAL HISTORY: (Please circle any/all of the following that you have experienced.)

AIDS	Depression	Heart Attack/Angina	Osteoporosis
Anemia	Diabetes	Hepatitis C	Peripheral Vascular Disease
Anxiety Problem	Diverticulosis	High Blood Pressure	Polio
Arthritis	Ear Trouble	HIV	Psychological/Psychiatric Problem
Asthma	Endometriosis	Irregular Heart Beat	Rheumatic Fever
Bipolar Disease	Enlarged Prostate	Irritable Bowel Syndrome	Scoliosis
Cancer	Fibromyalgia	Jaundice	Seizures
Colon Polyp	Gastritis	Kidney Disease	Sexually Transmitted Disease
Congestive Heart Failure	Glaucoma	Kidney Stones	Stroke
COPD/Emphysema	Gout	Liver Disease	Thyroid Disease
Deep Venous Thrombosis	Head Injury	Lupus	Tuberculosis
			Ulcers

Other Medical Problems: _____

Allergies: _____

Injuries: Please list all fractures, injuries, and motor vehicles accidents.

Year Injured	Nature of Injury	Year Injured	Nature of Injury
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Hospitalizations/Surgeries:

Year	Reason for Hospitalization/Surgery	Year	Reason for Hospitalization/Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please continue on the other side ♥

Have you ever had a blood transfusion? YES NO

SOCIAL HISTORY:

Do you smoke now? NO YES _____ packs/day _____ # of yrs.

Did you smoke in the past? NO YES _____ packs/day _____ # of yrs.

Do you drink alcohol? NO YES _____ number of drinks/wk.

Do you have a history of drug/alcohol abuse? NO YES

Your level of education: Grade School High School Associate Degree
 Bachelor Degree Graduate School

FAMILY HISTORY:

Please check the box of any/all of the following problems that your blood relatives (e.g., parents, Brothers, sisters, grandparents, aunts, uncles, children), have had:

<u>Illness</u>	<u>Relative/Family Member (i.e., Mom, Grandfather)</u>
<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Back or Neck Surgery	_____
<input type="checkbox"/> Back Pain/Sciatica	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Heart Attack/Heart Disease	_____
<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Mental Illness	_____
<input type="checkbox"/> Muscle Disease	_____
<input type="checkbox"/> Neck Pain	_____
<input type="checkbox"/> Nerve Disease	_____
<input type="checkbox"/> Stroke	_____

Relation	Age	State Of Health/ Medical Problems	If Deceased, Cause Of Death	Age At Death
Father				
Mother				
Brothers and Sisters				
Spouse				
Children				