

MEDICAL HISTORY FORM



Name: _____
MR#: _____
Date: _____

Weight: _____ Height: _____ Age: _____

Past Medical History/Review of Systems

Please check (X) the box next to any illnesses or problems that apply to you.

- | | | | | |
|--------------------------------------|---|--|---|---------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis/HIV | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Arthritis | |

Please Explain: _____
 Other: _____

Skeletal Health:
 History of falls/fractures? Steroid Use?
 Do you smoke or drink?
 Vitamin deficiency?
 Do you exercise infrequently?
 Do you have a thin or petite build?
 Have you ever had a Bone Density Test?

Surgery / Fractures

Please check (X) the box next to any surgical procedures which you have had.

- | | | | | |
|--|----------------------------------|--|--|---------------------------------------|
| <input type="checkbox"/> Tonsils | <input type="checkbox"/> Breast | <input type="checkbox"/> Appendix | <input type="checkbox"/> Uterus | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Ovaries | <input type="checkbox"/> Stomach | <input type="checkbox"/> Prostate | <input type="checkbox"/> Small Intestine | <input type="checkbox"/> Colon |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Kidney | <input type="checkbox"/> Hernia (repair) | <input type="checkbox"/> Heart | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Joint Replacement | | <input type="checkbox"/> Arthroscopy | | |
- Extremities, Neck, Back (What kind): _____
 Any other surgeries (What kind): _____

Allergies Please check allergies that apply to you.(X) the box next to any

If you do not have allergies please check (X) none.

- Penicillin Sulfa Metal None

Other Antibiotics or other Drugs/medications
What kind: _____

Any foods/cosmetics or other allergies
What kind: _____

Medications (blood thinners, non-prescription remedies?)

Name of drug and how often it is taken:

Do you have any of the following Conditions?

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Frequent / Painful Urination |
| <input type="checkbox"/> Unexpected Weight Loss | <input type="checkbox"/> Fever / Chills | <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness in Extremities |
| <input type="checkbox"/> Constipation / Diarrhea / Blood in stools | | | |

Tobacco Use

Cigarettes: Yes / No Packs/day _____ Years of use _____
Other tobacco use: _____

Alcohol Use: Beer/Wine: _____ x a week

Shots/Liquor: _____ x a week
 Other drug use: _____

Family History

Please check (X) the box next to any disease diagnosed in your blood relatives.

- | | | | |
|---------------------------------------|--|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Other type of arthritis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Other: _____ | | | |

Social History

Are you? Single Married Divorced Widowed
Work Status: Unemployed Disabled Retired Student

Employed – Doing what? _____

Who lives in your house that can care for you or for whom you have to care? _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

PHYSICIAN NUMBER _____

Sign Here: _____