MEDICAL HISTORY INFORMATION FORM

Patient Name: _____ DOB: _____ Referring Doctor: _____

Reason for visit (body part and side): _____
Was this a work injury? If so, did you file a workman's compensation claim?

MEDICATIONS: _____
Note medication name, and dose**.** You may use the back of this sheet if you need additional space.

Medication Name	**Dose**	**Medication Name**	**Dose**	**Medication Name**	**Dose**
_____	____	_____	____	_____	____
_____	____	_____	____	_____	____
_____	____	_____	____	_____	____
_____	____	_____	____	_____	____
_____	____	_____	____	_____	____

Do you have any allergies to medication? _____

SOCIAL HISTORY: _____
Are you a **current** smoker? YES/NO If current, how much per day? Are you a **former** smoker? YES/NO
Do you drink alcohol? _____ If so, how much/how often? _____Are you pregnant? _____

MEDICAL HISTORY: _____
Please list all previous surgeries below. Be sure to include the type of procedure, and year preformed.

_____
_____

Chronic Medical Conditions
(Please check all that apply)

High Blood Pressure	
High Cholesterol	
Heart Trouble	
Cancer	
Stroke	
Thyroid (Hypo/Hyper)	
Chronic Kidney Disease	
Diabetes	
Asthma/COPD	
Depression/Anxiety	

Additional Medical Conditions:
(Please include any medical conditions not listed)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Family Medical History
(Please check all that apply)

	Father	Mother	Sister	Brother
High Blood Pressure				
High Cholesterol				
Cancer				
Heart Trouble				
Diabetes				

Additional Family Medical Conditions:
(Please include any medical conditions not listed)

_____
_____
_____
_____
_____
_____
_____
_____