MEDICAL HISTORY INFORMATION FORM

Patient Name:_____ Date:_____

HISTORY

Reason for visit (body part and side):_____

Was this a work injury?_____ If so, did you file a workman's compensation claim?_____

DRUG ALLERGIES & REACTION: _____

Pharmacy Name & Location_____**Pharmacy Phone #**_____

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

Medication Name	Dose	**Medication Name**	Dose

SOCIAL HISTORY

Are you a **current** or **former** smoker?(if yes, please circle one)_____ If current, how much per day?_____
Do you drink alcohol?_____ If so, how much and how often?_____
Are you pregnant?_____

PREVIOUS SURGERY (Type and Date)

_____ _____
_____ _____
_____ _____
_____ _____

MEDICAL PROBLEMS Please mark any medical issues for yourself **and** your family. Please notate **WHAT** particular type of health issue (ex, if you mark "heart trouble", please notate type—A Fib, heart disease, etc) and **WHO** in your family (if any) experience this health issue. For health issues not mentioned below, please add in space provided.

	Self	**Family**	**Type/Who**	**Additional Medical Problems**
Diabetes				
High Blood Pressure				
Cancer				
Stroke				
Heart Trouble				
Reflux (GERD)				
Thyroid			Hypo? Hyper?	
Asthma/COPD				
High Cholesterol				
Depression				