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

ALLERGIES TO MEDICATIONS: ____

SOCIAL HISTORY:

Are you a **current** smoker? YES/NO If current, how much per day?_______Are you a **former** smoker?YES/NO If yes, how long has it been since you last smoked?

Do you drink alcohol? ______ If so, how much/how often? _________________Are you pregnant? _________

MEDICAL HISTORY:

SURGERIES: 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)

____

____

____

____

____