

MEDICAL HISTORY FORM

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_

CHIEF COMPLAINT

Why are you seeing the doctor today? \_\_\_\_\_

Current problem is a result of: \_\_\_ Car Accident \_\_\_ Work Accident \_\_\_ Other (Explain) \_\_\_\_\_

Have you ever been treated for this condition before? \_\_\_ Yes \_\_\_ No

By Whom? \_\_\_\_\_ When? \_\_\_\_\_

MEDICATIONS: *Please list*

Name	Dose	Reason for Medication	Side Effects

ALLERGIES TO MEDICATIONS: \_\_\_\_\_

ALLERGIES TO LATEX: \_\_\_ Yes \_\_\_ No

Are all immunizations up to date? \_\_\_ Yes \_\_\_ No If no, which immunizations are due? \_\_\_\_\_

REVIEW OF SYMPTOMS

Are you currently having or have you ever had any problems with:

	<i>Circle one</i>	<i>Describe all YES responses</i>
Eyes	No Yes	_____
Ears, Nose, Throat	No Yes	_____
Lungs, Breathing	No Yes	_____
Digestion	No Yes	_____
Bowel Movement	No Yes	_____
Bladder Problem	No Yes	_____
Diabetes	No Yes	_____
High blood Pressure	No Yes	_____
Bleeding Problems	No Yes	_____
Balance Problems	No Yes	_____
Numbness/tingling	No Yes	_____
Blackouts/fainting	No Yes	_____
Psychological Problems	No Yes	_____
AIDS	No Yes	_____
Cancer	No Yes	_____
Arthritis	No Yes	_____
Polio	No Yes	_____
Tuberculosis	No Yes	_____
Epilepsy	No Yes	_____

**PAST MEDICAL HISTORY (Please List)**

Surgeries/Hospitalizations                      Year                      Complications

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Have you ever had general anesthesia?                      \_\_\_ Yes                      \_\_\_ No  
 Did you have any problems with anesthesia?                      \_\_\_ Yes                      \_\_\_ No

**FAMILY HISTORY**

	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	___	___	___	_____
Grandfather (mom's)	___	___	___	_____
Grandmother (dad's)	___	___	___	_____
Grandfather (dad's)	___	___	___	_____
Mother	___	___	___	_____
Father	___	___	___	_____
Sister/Brother	___	___	___	_____
Sister/Brother	___	___	___	_____
Sister/Brother	___	___	___	_____
Sister/Brother	___	___	___	_____

**SOCIAL HISTORY**

Employed (Occupation \_\_\_\_\_)     Work in the home     Student     Retired     Daycare  
 Single     Married     Divorced     Separated     Widowed  
 Children?     No     Yes    How many? \_\_\_\_\_  
 Do you live alone?     No     Yes  
 History of substance abuse?     No     Yes    What substance? \_\_\_\_\_  
 Smoke currently?     No     Yes    \_\_\_\_\_ Packs per day for \_\_\_\_\_ years  
 Quit smoking?     This year     >1 year     >5 years     >10 years  
 Previously smoked \_\_\_\_\_ packs per day for \_\_\_\_\_ years  
 Drink alcohol?     Daily     1-2x/week     1-2x/month     1-2x/year

**ORTHOPAEDIC HISTORY**

Hand Dominance    \_\_\_ Right    \_\_\_ Left

Please list any previous fractures:

Bone	Date	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_ MD DATE \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_ MD DATE \_\_\_\_\_