Medical History Form

Patient Name: _____ DOB: _____ Sex: ❑F ❑ M

Hand Dominance: ❑ R ❑L Height (feet, inches): _____ Weight (lbs.) _____

Reason for visit: _____

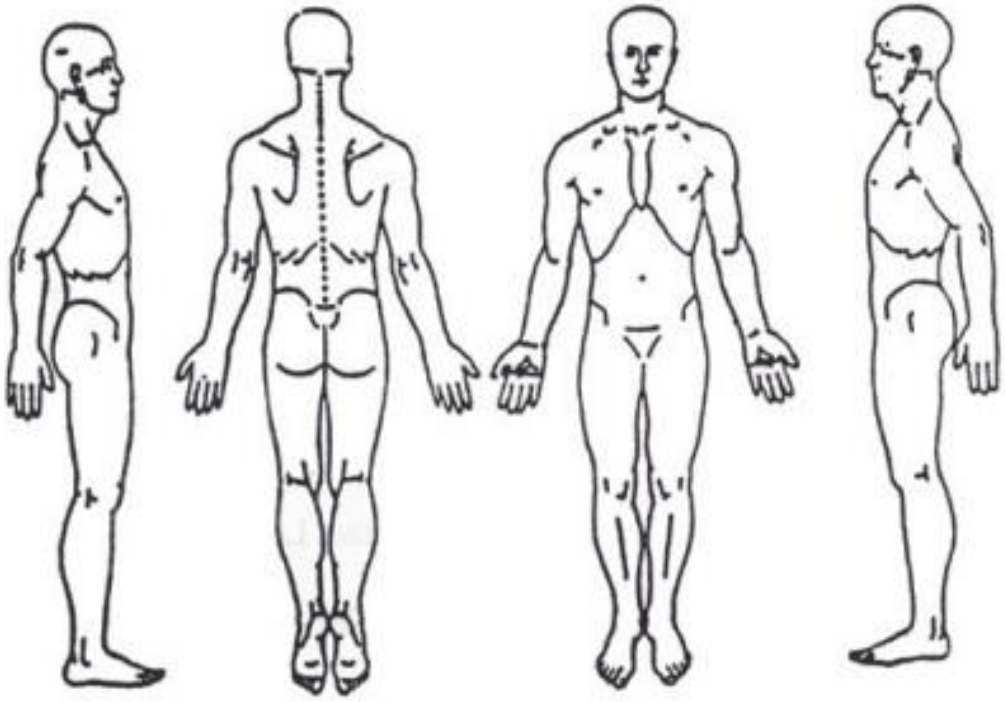
Describe how your illness or pain began, include date(s) if known:

_____

Please use the key symbols to mark where you feel that type of sensation on the body:

Key:

===	numbness
^^^	ache
000	pins and needles
///	stabbing
XXX	burning
---	shooting
***	tingling



Is there anything that makes your pain/symptoms WORSE?	Is there anything that makes your pain/symptoms BETTER?

Check box (X) that describes:	0 None	1-2 Mild	3-4 Uncomfortable	5-6 Distressing (fairly severe)	7-8 Very Severe (horrible)	9-10 Unbearable (excruciating)
Pain as it usually feels	❑	❑	❑	❑	❑	❑
Pain at its worse	❑	❑	❑	❑	❑	❑
Pain at its least or no pain	❑	❑	❑	❑	❑	❑
How many days a week do you experience pain?	❑ Daily	❑ 1-2	❑ 3-4	❑ 5-6	❑ Intermittent	

Medical History Form

Have you had any of the following treatments or testing for your conditions? (Check all that apply)	
❑ Surgery Date(s)?	❑ Injections Date or last injection? What was injected?
❑ Chiropractic or Osteopathic Adjustments	❑ Physical Therapy
❑ Acupuncture	❑ Massage
❑ Prescription Medication	❑ OTC Medication (e.g., ibuprofen, acetaminophen)
❑ X-ray	❑ MRI
❑ Ultrasound	❑ CT
❑ EMG/NCV	❑ Other:

PAST MEDICAL HISTORY ❑ None Do you now or have you ever had:			
❑ Anemia	❑ Deep Vein Thrombosis	❑ High Blood Pressure	❑ Osteoporosis/Osteopenia
❑ Anemia	❑ Diabetes	❑ HIV/AIDS	❑ Rheumatoid Arthritis
❑ Asthma	❑ Gout	❑ Hyperthyroid	❑ Seizures
❑ Bleeding Disorder	❑ Heart Attack	❑ Hypothyroid	❑ Sleep Disorders
❑ Broken Bones	❑ Heart Murmur	❑ Low Platelet Count	❑ Stoke
❑ Cancer	❑ Hepatitis	❑ Osteoarthritis	❑ Stomach Ulcers
❑ Other (Please list)			

Have you had any adverse reactions to local anesthetics? (e.g., Novocain, lidocaine)

❑ Yes ❑ No ❑ Unknown What was your reaction? _____

Have you had any adverse reactions to sedation?

❑ Yes ❑ No ❑ Unknown What was your reaction? _____

Injuries: Automobile accident, fractures, strains, sprains, concussion, any other ❑ No injuries

_____

_____

Surgeries: Please include dates ❑ No surgeries

_____

_____

Medical History Form

In the *past month*, have you had any of the following problems?

GENERAL
- ❑ Unplanned weight change
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Loss of Motion
- ❑ Stiffness

ENT
- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Difficulty swallowing
- ❑ Pain in jaw
- ❑ Sore throat

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss
- ❑ Seizures
- ❑ Paralysis

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Persistent diarrhea
- ❑ Black or bloody stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Bruising
- ❑ Bleeding
- ❑ Clots

EYES
- ❑ Blurred vision
- ❑ Loss of vision
- ❑ Double vision

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine
- ❑ Incontinence
- ❑ Urgency

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Change in sleep pattern
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Hallucinations
- ❑ Nervousness
- ❑ Mood swings
- ❑ Anxiety

OTHER PROBLEMS:

_____

_____

Allergies: List all medication, environmental, food, or chemical allergies and type of reaction ❑ No allergies

_____

_____

Prescription Medications: ❑ None

_____

_____

Over the Counter Medications, Supplements, Vitamins, Creams, Eye Drops, Oils, or Others ❑ None

_____

_____

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Medical History Form

Pharmacy Information
Pharmacy Name:
Pharmacy Address:
Pharmacy Phone #:

Social History	Occupation:			
	Marital Status:	❑ Single ❑Married ❑ Divorced ❑ Widowed ❑ Other		
	Do you exercise?	❑ Yes ❑ No	If yes, what type and how often?	
	Do you us tobacco?	❑ Yes ❑ No	If yes, how often?	
	Do you use alcohol?	❑ Yes ❑ No	If yes, how often?	
	Do you use recreational drugs?	❑ Yes ❑ No	If yes, how often?	
	What are your interests or hobbies?			

Family History	❑ Arthritis (any type)	❑ Cancer	❑ Diabetes
	❑ Heart Problems	❑ Osteoporosis	❑ Stroke
	❑ No family history of medical problems	❑ Other:	