



MR#

Patient Medical History Form

Name: _____ Date: _____

DOB: _____ Hand Dominance: Right Left

Height: _____ Weight: _____

Pain Contract: Yes No Pain Dr.: _____

Medical History: Please check all boxes that apply.

- | | | |
|---|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis / Rheumatoid | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis A B C |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Immune System Disorder |
| <input type="checkbox"/> Cold Sensitivities | <input type="checkbox"/> Ulcers or Reflux | <input type="checkbox"/> Blood Clots or Family History |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Cancer Type: _____ |
| <input type="checkbox"/> Other: _____ | | |

Past Surgeries and/or Hospitalizations: Please include approximate date.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current Medication: Please provide dose and frequency.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: Please include type of reaction. No known allergies Latex

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Social History:

MR #

Home Life: Single Married Divorced Widowed Domestic Partnership
 Children

Employment Status: Full-time Part-time Retired Homemaker Disabled

Occupation: _____

Recreational Hobbies / Sports: _____

Smoking: Never Previously (year quit) _____ Current (packs/day) _____

Alcohol Use: No Yes If yes, # Drinks per: Day _____ Week _____ Month _____

Recreational Drug Use: Never Previously* Currently* *Please specify: _____

Family History: Please mark all that apply and specify parents, grandparents, siblings.

Cancer _____ Heart Disease _____ Arthritis _____

Reaction to Anesthesia _____ Blood Clots / Abnormal Bleeding _____

Diabetes _____

Review of Current Symptoms Are you currently having or have had problems with: (Mark all that apply)

General

- Fevers
- Chills
- Fatigue
- Weight Changes
- Night Sweats

Head/Eye/Ears/Nose/Throat

- Frequent Headaches
- Hearing Loss
- Corrective Vision
- Dentures
- Mouth or Dental Infections

Gastrointestinal

- Nausea
- Vomiting
- Ulcers
- GI Bleeding

Genitourinary

- Incontinence
- Bladder infections
- Kidney Stones
- Difficulty Urinating

Musculoskeletal

- Joint Pain
- Fractures
- Gout
- Osteoporosis
- Arthritis

Respiratory

- Shortness of Breath
- Wheezing
- Cough
- Asthma

Neurological

- Stroke
- Seizures
- Frequent Falls
- Dizziness
- Nerve Damage

Psychiatric

- Anxiety
- Depression
- Bipolar
- Inability to sleep
- Mood/Behavior Changes

Skin/Integumentary

- Rashes
- Cancer
- Skin Disorders
- Connective Tissue Disorders
- Open Wounds or Sores
- Cold Sensitivity

Cardiovascular

- Chest Pain
- Irregular Heart Beat
- Heart Murmurs
- Blood clots in legs or lungs

Notes:

Patient Signature: _____ Date: _____

Do Not Write Below This Line

Vital Signs

Date	Height	Weight	Blood Pressure	Pulse	BMI	Nurse
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Physician Signature & Date:

