MEDICAL HISTORY

NAME: _____ AGE: _____ DATE: _____

PLEASE DESCRIBE YOUR CURRENT PROBLEM (be specific: left or right, accident, gradual onset, etc):

_____

_____

_____

Your Dominant hand: right or left Date of onset: _____ Work related? _____

FOR THIS PROBLEM HAVE YOU HAD:

X-Rays? _____Yes _____ No Date: _____ At what facility? _____

MRI, CT Scan, or other tests? _____Yes _____No What Type _____ Where _____

Have you had any treatment? _____Yes _____No What Type _____

Have you had any Physical or Occupational Therapy? _____Yes _____No Where? _____

Please list any medicines taken for **this problem**: _____

_____

Are you currently working? ____Yes ___ No Job description _____

Past Medical History:	Yourself Yes	No	
Arthritis	___	___	
Asthma	___	___	
Bronchitis	___	___	
Cancer	___	___	Type: _____
Depression	___	___	
Diabetes	___	___	
Drug/alcohol dependency	___	___	
Fibromyalgia	___	___	
Gout	___	___	
Heart disease	___	___	
High blood pressure	___	___	
Hypothyroidism	___	___	
Lung disease	___	___	
Pneumonia	___	___	
Reflux	___	___	
Seizures	___	___	
Sleep apnea	___	___	
Stomach ulcers	___	___	
Stroke	___	___	
Problems with anesthesia	___	___	
	Relative Yes	No	
Severe arthritis	___	___	
Problems with anesthesia	___	___	

Any prior operations? ____ Yes ____No

Please list and date operations below:

_____

_____

_____

Implanted Cardiac Devices? ____Yes ____No

Are you taking any medications? ____Yes ____No

Please carefully list or attach separate sheet:

_____

_____

_____

Are you allergic to any medications? ____Yes ____No

Please list any drug allergies and the side effect:

_____

_____

	Yes	No
Do you have a communicable disease? (hepatitis, HIV)	___	___
Social History:		
Do you drink alcohol?	___	___
Do you smoke?	___	___
Do you use smokeless tobacco?	___	___

REVIEW OF SYSTEMS

Do you have any of the following?

	Yes	No
CONSTITUTIONAL		
Recent fever	___	___
RESPIRATORY		
Cough	___	___
Shortness of breath	___	___
Wheezes	___	___
CARDIOVASCULAR		
Chest pain	___	___
Palpitations	___	___
GASTROINTESTINAL		
Abdominal pain	___	___
Blood in stool	___	___
Sensitive stomach	___	___
KIDNEY/BLADDER		
Difficulty urinating	___	___
Loss of bladder control	___	___
BONE/JOINT		
Swollen joints	___	___
NEUROLOGIC		
Headaches	___	___
Numbness	___	___
Visual changes	___	___
HEMATOLOGY		
Easy bruising	___	___
Easy bleeding	___	___