Name: ____________________________ Date: ____________________________

Orthopedic History: ________________________________________________________________

Reason for Visit: _________________________________________________________________

Is this problem a result of:  
- [ ] MVA  
- [ ] Liability  
- [ ] Work Related (Comp)  
- [ ] Trauma  
- [ ] Gradual  
- [ ] Recurrent

Date of Injury: __/__/____  Description of injury: ________________________________

Side:  
- [ ] Right  
- [ ] Left  

Dominant:  
- [ ] Right Handed  
- [ ] Left Handed

History of Present Injury or Complaint:

Do you now have or have you ever had:

CONSTITUTIONAL:

Recent weight changes  
- [ ] Yes  
- [ ] No

Recent fever, weakness or fatigue  
- [ ] Yes  
- [ ] No

EYES:

Wear glasses or contact lenses  
- [ ] Yes  
- [ ] No

Glaucoma  
- [ ] Yes  
- [ ] No  

Family History  
- [ ] Yes  
- [ ] No  

Member: ____________________________

Cataracts  
- [ ] Yes  
- [ ] No  

Family History  
- [ ] Yes  
- [ ] No  

Member: ____________________________

EARS, NOSE, THROAT:

Hearing Problems  
- [ ] Yes  
- [ ] No

Dizziness  
- [ ] Yes  
- [ ] No

Recent cold or sinus pain  
- [ ] Yes  
- [ ] No

Recent sore throat  
- [ ] Yes  
- [ ] No

Hoarseness or difficulty swallowing  
- [ ] Yes  
- [ ] No

CARDIOVASCULAR:

Chest Pain  
- [ ] Yes  
- [ ] No

Heart Attack  
- [ ] Yes  
- [ ] No  

Family History  
- [ ] Yes  
- [ ] No  

Member: ____________________________

Stroke  
- [ ] Yes  
- [ ] No  

Family History  
- [ ] Yes  
- [ ] No  

Member: ____________________________

Heart Failure  
- [ ] Yes  
- [ ] No  

Family History  
- [ ] Yes  
- [ ] No  

Member: ____________________________

High Blood Pressure  
- [ ] Yes  
- [ ] No  

Family History  
- [ ] Yes  
- [ ] No  

Member: ____________________________

Irregular Heartbeat  
- [ ] Yes  
- [ ] No  

Family History  
- [ ] Yes  
- [ ] No  

Member: ____________________________

Swelling of Hands or Feet  
- [ ] Yes  
- [ ] No

Blood Clots  
- [ ] Yes  
- [ ] No  

Family History  
- [ ] Yes  
- [ ] No  

Member: ____________________________

RESPIRATORY:

Asthma  
- [ ] Yes  
- [ ] No  

Family History  
- [ ] Yes  
- [ ] No  

Member: ____________________________

Emphysema  
- [ ] Yes  
- [ ] No  

Family History  
- [ ] Yes  
- [ ] No  

Member: ____________________________

Bronchitis  
- [ ] Yes  
- [ ] No  

Family History  
- [ ] Yes  
- [ ] No  

Member: ____________________________

Pneumonia  
- [ ] Yes  
- [ ] No  

Family History  
- [ ] Yes  
- [ ] No  

Member: ____________________________

Tuberculosis  
- [ ] Yes  
- [ ] No  

Family History  
- [ ] Yes  
- [ ] No  

Member: ____________________________
## MEDICAL HISTORY FORM

### GASTROINTESTINAL:
- Recent changes in bowel habits
  - [ ] Yes
  - [ ] No
- Rectal Bleeding
  - [ ] Yes
  - [ ] No
- Liver Disease
  - [ ] Yes
  - [ ] No
  - Family History
    - [ ] Yes
    - [ ] No
    - Member: ________________________________

### URINARY:
- Problems with urination
  - [ ] Yes
  - [ ] No
- Urinary tract infections
  - [ ] Yes
  - [ ] No
- Kidney Disease
  - [ ] Yes
  - [ ] No
  - Family History
    - [ ] Yes
    - [ ] No
    - Member: ________________________________

### SKIN:
- Recent or current rashes or eruptions
  - [ ] Yes
  - [ ] No
  - Where: ________________________________

### NEUROLOGICAL:
- Seizures
  - [ ] Yes
  - [ ] No
  - Family History
    - [ ] Yes
    - [ ] No
    - Member: ________________________________
- Paralysis
  - [ ] Yes
  - [ ] No
  - Where: ________________________________
- Numbness or tingling
  - [ ] Yes
  - [ ] No
  - Where: ________________________________

### ENDOCRINE:
- Thyroid
  - [ ] Yes
  - [ ] No
  - Family History
    - [ ] Yes
    - [ ] No
    - Member: ________________________________
- Diabetes
  - [ ] Yes
  - [ ] No
  - Family History
    - [ ] Yes
    - [ ] No
    - Member: ________________________________
  - Treatment:
    - [ ] Diet
    - [ ] Oral Meds
    - [ ] Insulin
- Medical Complications:
  - [ ] Vascular
  - [ ] Renal
  - [ ] Neuropathy
  - [ ] Other: ________________________________

### HEMATOLOGIC/LYMPHATIC:
- Anemi
  - [ ] Yes
  - [ ] No
  - Family History
    - [ ] Yes
    - [ ] No
    - Member: ________________________________
- Transfusions
  - [ ] Yes
  - [ ] No
  - Family History
    - [ ] Yes
    - [ ] No
    - Member: ________________________________
- CANCER/TUMOR:
  - [ ] Yes
  - [ ] No
  - Family History
    - [ ] Yes
    - [ ] No
    - Member: ________________________________
  - Type: ________________________________
  - Location: ________________________________
  - Treatment: ________________________________

### OTHER MEDICAL PROBLEMS:
- ________________________________
- ________________________________
- ________________________________

### HISTORY OF OPERATIONS:
- [ ] Yes
  - [ ] No
  - Type: ________________________________
- ________________________________
- ________________________________

### DO YOU HAVE ALLERGIES, SENSITIVITIES OR HAVE YOU AN ADVERSE REACTION TO MEDICATIONS:
- [ ] Yes
  - [ ] No
  - Please List: ________________________________
- ________________________________
- ________________________________

### CURRENT MEDICATIONS:
- ________________________________
- ________________________________

When did you last use aspirin in any form:

______________
MEDICAL HISTORY FORM

PERSONAL HISTORY:

Cigarettes ☐ Yes ☐ No Amount: ________________________________

Alcohol ☐ Yes ☐ No Amount: ________________________________

OCCUPATION: ______________________________________________

TESTS DONE RELATED TO PRESENT INJURY OR COMPLAINT:

☐ X-rays ☐ MRI ☐ CT Scan ☐ EMG ☐ Bone Scan ☐ Bone Density ☐ Bloodwork

Tests performed at: ________________________________________

PRIOR TREATMENT (best recollection - Check and explain):

☐ Anti-Inflammatories:

☐ Injections (dates & number):

☐ Chiropractic:

☐ Surgery:

Physical Therapy: ☐ Ultrasound ☐ Massage ☐ Strengthening ☐ ROM Stretching

☐ Cybex Machines ☐ Cryotherapy ☐ Cortisone Cream ☐ Manipulation

☐ Electrical Stimulation

YOUR MEDICAL DOCTOR:

Name: ____________________________________________________

Address: ________________________________________________

Phone: __________________________________________________

YOUR REFERRING DOCTOR:

Name: __________________________________________________

Address: ________________________________________________

Phone: __________________________________________________

PATIENT SIGNATURE: ____________________________________________

MD SIGNATURE/DATE: ____________________________________________