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MEDICAL HISTORY FORM

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 Presure	❑ 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:	_____

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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 asprin in any form: _____

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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: ❑ Ulttrasound ❑ Masage ❑ Strengthening ❑ ROM Stretching
❑ Cybex Machines ❑ Cryotherapy ❑ Cortisone Cream ❑ Maniuplation
❑ Electrical Stimulation

YOUR MEDICAL DOCTOR: Name: _____

Address: _____

Phone: _____

YOUR REFERRING DOCTOR: Name: _____

Address: _____

Phone: _____

PATIENT SIGNATURE: _____

MD SIGNATURE/DATE: _____