

# MEDICAL INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Who recommended that you see us? \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

## YOUR CURRENT PROBLEM

\*What is bothering you? \_\_\_\_\_

\*When did your current problem start? \_\_\_\_\_

\*Were you injured at work?  yes  no

\*Last day on the job: \_\_\_\_\_ Do you expect to be working 6 mos. from now?  yes  no

\*Were you injured in a motor vehicle accident?  yes  no

## MEDICATIONS

\*Required: Pharmacy Name \_\_\_\_\_ Phone Number \_\_\_\_\_

\*List your medications (include dosage and frequency):

\_\_\_\_\_  
\_\_\_\_\_

## ALLERGIES

\*Do you have any allergies to latex or medications?  yes  no If yes, please list:

\_\_\_\_\_

## PAST MEDICAL HISTORY

\*Have you ever tested positive for:

**Hepatitis**  yes  no **Tuberculosis**  yes  no or **HIV (AIDS)**  yes  no

\*Do you have: **High Blood Pressure, High Cholesterol, Diabetes, or Thyroid Problems?** (please circle)

\*Do you or have you ever had any of the following conditions? (please circle)

**Heart Problems:** Heart Attack, Angina, Anemia, Other: \_\_\_\_\_

**Lung Problems:** Asthma, Emphysema, Pneumonia, Other: \_\_\_\_\_

**Stomach Problems:** Ulcers, Reflux, Bleeding, Polyps, Other: \_\_\_\_\_

**Nerve/Brain Problems:** Stroke, Seizures, Nerve Injuries, Other: \_\_\_\_\_

**Eye Problems:** Cataracts, Glaucoma, Other: \_\_\_\_\_

**Immunology Problems:** Rheumatoid Arthritis, Other: \_\_\_\_\_

**Psychological Problems:** Depression, Anxiety, Mania, Other: \_\_\_\_\_

**Cancer of:** \_\_\_\_\_

\*List any operations or serious illnesses you have had:

Date	Operation or illness
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_____	_____
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_____	_____
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_____	_____
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\*Have you or any one in your family had any problems with anesthesia? 0 yes 0 no

If yes, please explain: \_\_\_\_\_

\*Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**TESTING**

\*List medical testing including X-Ray studies you have had pertaining to this problem.

Date	Test Performed	Location/Test Site
_____	_____	_____
_____	_____	_____
_____	_____	_____

**REVIEW OF SYSTEMS**

\*Do you have any of the following? (please check)

	YES	NO		YES	NO		YES	NO
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Voice Changes	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Unusual Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Heavy Sputum	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Slow to Heal	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Back/Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>	Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Freq. Urination	<input type="checkbox"/>	<input type="checkbox"/>	Lumps/Cysts	<input type="checkbox"/>	<input type="checkbox"/>
Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Other _____								

**SOCIAL HISTORY**

- \*Do you smoke?  yes  no If yes, how much? \_
- \*Do you drink alcohol?  yes  no If yes, how much/day? \_
- \*Have you ever used recreational drugs?  yes  no
- \*Marital Status:  Single  Married  Divorced  Widowed

**FAMILY HISTORY**

\*Do any of the following conditions run in your family?

yes	no	Condition	How Related
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	_____

**Patient or Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I have reviewed this information and have made the necessary changes.

_____	_____	_____
Signature	Date	
_____	_____	_____
Signature	Date	
_____	_____	_____
Signature	Date	