MEDICAL HISTORY FORM

Name: _____

MR#: _____

Date: _____

Weight:_____ Height:_____ Age:_____

Past Medical History/Review of Systems

Please check (X) the box next to any illnesses or problems that apply to you.

☐ Cancer	☐ Asthma	☐ Tuberculosis/HIV	☐ Liver Disorder	☐ Diabetes
☐ Alcoholism	☐ Heart Trouble	☐ Emphysema/COPD	☐ Birth Defects	☐ Heart Attack
☐ Ulcers	☐ Kidney Disease	☐ High Blood Pressure	☐ Stroke	☐ Gout
☐ Cholesterol	☐ Sickle Cell Anemia	☐ Bleeding Disorder	☐ Arthritis	

Please Explain: _____

☐ Other: _____

Skeletal Health:

☐ History of falls/fractures? ☐ Steroid Use?
☐ Do you smoke or drink?
☐ Vitamin deficiency?
☐ Do you exercise infrequently?
☐ Do you have a thin or petite build?
☐ Have you ever had a Bone Density Test?

Surgery / Fractures

Please check (X) the box next to any surgical procedures which you have had.

☐ Tonsils	☐ Breast	☐ Appendix	☐ Uterus	☐ Gall Bladder
☐ Ovaries	☐ Stomach	☐ Prostate	☐ Small Intestine	☐ Colon
☐ Thyroid	☐ Kidney	☐ Hernia (repair)	☐ Heart	☐ Pacemaker
☐ Joint Replacement		☐ Arthroscopy		

☐ Extremities, Neck, Back (What kind): _____ _____

☐ Any other surgeries (What kind): _____

Allergies **Please check allergies that apply to you.(X) the box next to any**
If you do not have allergies please check (X) none.

☐ Penicillin ☐ Sulfa ☐ Metal ☐ None

☐ Other Antibiotics or other Drugs/medications
What kind: _____

☐ Any foods/cosmetics or other allergies
What kind: _____

Medications (blood thinners, non-prescription remedies?)
Name of drug and how often it is taken:

_____
_____
_____
_____ _____
_____
_____
_____

Do you have any of the following Conditions?

☐ Shortness of breath	☐ Chest Pain	☐ Blurred Vision	☐ Frequent / Painful Urination
☐ Unexpected Weight Loss	☐ Fever / Chills	☐ Headaches	☐ Numbness in Extremities
☐ Constipation / Diarrhea / Blood in stools			

Tobacco Use
Cigarettes: Yes / No Packs/day _____ Years of use _____
Other tobacco use: _____

Alcohol Use:
☐ Beer/Wine: _____ x a week
☐ Shots/Liquor: _____ x a week
☐ Other drug use: _____ _____

Family History

Please check (X) the box next to any disease diagnosed in your blood relatives.

☐ Cancer	☐ Diabetes	☐ Rheumatoid Arthritis	☐ Other type of arthritis
☐ Gout	☐ Bleeding Problems	☐ Sickle Cell Anemia	☐ Heart Disease

☐ Other: _____

Social History

Are you? ◯ Single ◯ Married ◯ Divorced ◯ Widowed
Work Status: ◯ Unemployed ◯ Disabled ◯ Retired ◯ Student

Employed – Doing what? _____

Who lives in your house that can care for you or for whom you have to care? _____

WHO IS YOUR PRIMARY CARE PHYSICIAN ? _____

PHYSICIAN NUMBER _____

Submit by Email

Sign Here: _____