Medical History Form Date: _____

Name: _____

Please fill out this information to the best of your ability. Please inform the physician when there are any changes.

Chief complaint _____.

Approximate duration of problem _____ If Injury, Date _____.

Previous treatment, if any _____.

Past medical history (please check box if you have been diagnosed, then explain):

- ☐ Metabolic/endocrine problems (i.e. diabetes): _____.
- ☐ Musculoskeletal: _____.
- ☐ Skin problems: _____.
- ☐ Cardiovascular disease (i.e. high blood pressure): _____.
- ☐ Respiratory disease (i.e. asthma): _____.
- ☐ Bleeding/circulation disorders (i.e. blood clots): _____.
- ☐ Gastrointestinal problems: _____.
- ☐ Nervous: _____.
- ☐ Any other medical problems: _____.

Please list medications:

_____
_____
_____
_____
_____
_____
_____
_____

Current systems: please check if you have-

- ☐ had recent, significant weight gain/loss.
- ☐ fevers or chills.
- ☐ shortness of breath.
- ☐ Musculoskeletal: limb numbness, weakness, or spasticity.
- ☐ severe calf cramping with walking.
- ☐ Cardiovascular
- ☐ Other

Please identify any allergies (check box and/or circle):

- ☐ Penicillin, or other antibiotics.
- ☐ Morphine, Demerol or Codeine.
- ☐ Novocain, or other anesthetics.
- ☐ Aspirin or other anti-inflammatory medications.
- ☐ Others: _____.
- ☐ Betadine/iodine/shellfish.
- ☐ Adhesive tape.
- ☐ Sulfa drugs.
- ☐ Latex.
- ☐ None known.

Please list reactions to any of the identified allergies _____.

Social history

Employment description _____.

Alcohol: ☐ none ☐ social ☐ moderate ☐ daily. *Tobacco:* ☐ never ☐ social ☐ daily, smoking approximately _____ packs per day.

Past surgical history _____.

Family medical history _____.