

MEDICAL HISTORY

Name _____ Date _____

Drug **ALLERGIES** (hives, rashes, vomiting or unable to breathe): Which medications can't you take?

Medication	Reaction	Medication	Reaction

Habits: Do you now or have you ever used tobacco? NO YES (please complete below)

Type of tobacco _____ Packs per day For _____ years Quit _____ years ago.

Do you drink alcohol? NO YES (please complete below) Type _____

_____ Drinks How frequently _____

Do you use recreational drugs? NO YES (please complete below)

What types? _____ How often? _____

PAST MEDICAL HISTORY: If you, or anyone in your family have had any of these medical problems, please check the appropriate box:

<u>You</u>	<u>Family</u>	<u>You</u>	<u>Family</u>	<u>You</u>	<u>Family</u>
<input type="checkbox"/>	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/> Parkinsons
<input type="checkbox"/>	<input type="checkbox"/> Alcoholism	<input type="checkbox"/>	<input type="checkbox"/> Blood Clots	<input type="checkbox"/>	<input type="checkbox"/> Ulcers
<input type="checkbox"/>	<input type="checkbox"/> Alzheimers	<input type="checkbox"/>	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/>	<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/> Renal Disease
<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Reflux (GERD)	<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Gout	<input type="checkbox"/>	<input type="checkbox"/> Scoliosis
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Seizures
<input type="checkbox"/>	<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/>	<input type="checkbox"/> Benign Prostatic Hypertrophy	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Lupus
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/> Spinal Stenosis
<input type="checkbox"/>	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/> Liver Disease	<input type="checkbox"/>	<input type="checkbox"/> Spondyloarthropathy
<input type="checkbox"/>	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/>	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/> COPD	<input type="checkbox"/>	<input type="checkbox"/> Migraines	<input type="checkbox"/>	<input type="checkbox"/> Heart Valve Disease
<input type="checkbox"/>	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/> Neuropathy
<input type="checkbox"/>	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Chronic Neck/Back Pain
<input type="checkbox"/>	<input type="checkbox"/> Degenerative Joint Disease	<input type="checkbox"/>	<input type="checkbox"/> Obesity	<input type="checkbox"/>	<input type="checkbox"/> Chronic Pain Syndrome
<input type="checkbox"/>	<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/> Malignant Hyperthermia
<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/> Keloid Scars
<input type="checkbox"/>	<input type="checkbox"/> MRSA	<input type="checkbox"/>	<input type="checkbox"/> Other _____		

OVER

Name _____ Date _____

Past surgical history: Please indicate if you have had any of the following surgeries

- | | Year | | Year |
|----------------------------------------------|-------|-----------------------------------------------|-------|
| <input type="checkbox"/> Heart Bypass (CABG) | _____ | <input type="checkbox"/> Hip Replacement | _____ |
| <input type="checkbox"/> Pacemaker | _____ | <input type="checkbox"/> Hip Surgery | _____ |
| <input type="checkbox"/> Heart Valve | _____ | <input type="checkbox"/> Knee Replacement | _____ |
| <input type="checkbox"/> Heart Stent | _____ | <input type="checkbox"/> Knee Arthroscopy | _____ |
| <input type="checkbox"/> Cancer Surgery | _____ | <input type="checkbox"/> Knee Surgery | _____ |
| <input type="checkbox"/> Prostate Surgery | _____ | <input type="checkbox"/> Shoulder Replacement | _____ |
| <input type="checkbox"/> Spine Surgery | _____ | <input type="checkbox"/> Shoulder Arthroscopy | _____ |
| | | <input type="checkbox"/> Shoulder Surgery | _____ |

Other Surgery _____

REVIEW OF SYSTEMS

Are you currently experiencing any of these conditions:

- | No | Yes | No | Yes | No | Yes |
|--------------------------|----------------------------------------------|--------------------------|-----------------------------------------------|--------------------------|-------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> Chills | <input type="checkbox"/> | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> Skin Infections |
| <input type="checkbox"/> | <input type="checkbox"/> Fever | <input type="checkbox"/> | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> | <input type="checkbox"/> Constipation | <input type="checkbox"/> | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> | <input type="checkbox"/> Vision Loss | <input type="checkbox"/> | <input type="checkbox"/> Heartburn | <input type="checkbox"/> | <input type="checkbox"/> Cold Intolerance |
| <input type="checkbox"/> | <input type="checkbox"/> Cough | <input type="checkbox"/> | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> | <input type="checkbox"/> Heat Intolerance |
| <input type="checkbox"/> | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> Bleeding tendencies | <input type="checkbox"/> | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> | <input type="checkbox"/> Depression |
| <input type="checkbox"/> | <input type="checkbox"/> Contact Dermatitis | <input type="checkbox"/> | <input type="checkbox"/> Metal Allergy | | |