

Medical History Form

Patient Name _____ Date _____
 Date of Birth _____ Phone # _____ Cell# _____ Work# _____
 Parent/Spouse _____ Cell# _____ Work# _____
 Emergency Contact _____ Phone# _____ Cell# _____

Chief Complaint

Why are you seeing the doctor today? _____

Current problem is the result of a(n): Check all that apply

- Car Accident Work Accident Accident
 Other _____

Date of injury or onset of condition: _____

Brief description of how injury happened or problem started: _____

Do you have an attorney for this injury? Yes No Name: _____
 Address: _____

Treatment thus far

Emergency Facility Evaluation Yes No Where? _____
 X-Rays? Yes No Where? _____
 Physical Therapy? Yes No
 Work Status (Occupation): _____ Disabled? Yes No
 Retired? Yes No
 Out of Work Yes No

Medication	Dosage	Times a Day

Are you taking any herbal or diet supplements? Yes No Please specify: _____

Allergies:	<input type="checkbox"/> Latex	<input type="checkbox"/> Iodine	<input type="checkbox"/> Food (specify)
	<input type="checkbox"/> None		<input type="checkbox"/> Medicine (specify)

Are you currently having or have you had problems with your (please CHECK):
 Describe all YES responses

Eyes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Ears, Nose, Throat	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Lungs, Breathing	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Digestion	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Bowel movement	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Bladder problem	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
High blood pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Bleeding problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Balance problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Numbness/tingling	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Blackout/fainting	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Psychological problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

AIDS No Yes _____
 Cancer No Yes _____
 Arthritis No Yes _____
 Polio No Yes _____
 TB No Yes _____
 Epilepsy No Yes _____

Previous Hospitalizations and Surgery: (BE SPECIFIC, INCLUDING DATES)

Family History

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)				
Grandfather (mom's)				
Grandmother (dad's)				
Grandfather (dad's)				
Father				
Mother				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Sister/Brother				

Social History

Marital Status: Single Married
 Children No Yes
 Do you live alone? No Yes
 Substance Abuse? No Yes
 Tobacco? No Yes
 Drink Alcohol? No Yes

CONSTITUTIONAL SIGNS: 1. Height _____ 2. Weight _____ lbs

PATIENT SIGNATURE: _____ DATE: _____