

MEDICAL HISTORY FORM

Patient name: _____ Referring Doctor: _____

Your answers on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any questions, do not answer it. Best estimates are fine if you cannot remember specific details. Thank you!

SYMPTOM AREA (left/right, leg, foot, toes, ankle): _____

When did you first notice symptoms: (date): _____

Describe how your symptoms began: _____

Treatment to date: _____ **Did it help?** _____

MEDICATIONS: Prescription and non-prescription medicines, vitamins/supplements, home remedies, birth control pills, herbs:

	<u>MEDICATIONS</u>	<u>DOSE</u>		<u>MEDICATIONS</u>	<u>DOSE</u>
1		6			
2		7			
3		8			
4		9			
5		10			

ALLERGIES or REACTIONS TO MEDICINES:

<u>MEDICATIONS</u>	<u>Reaction or Side Effect</u>

SURGICAL HISTORY (Please list all prior operations and dates):

	<u>OPERATION</u>	<u>DATE</u>		<u>OPERATION</u>	<u>DATE</u>
1		5			
2		6			
3		7			
4		8			

SOCIAL HISTORY:

Height: ft. in. Any recent height loss: Yes / No

Shoe Size:

Weight: lbs. Any recent weight gain? Yes / No how much:

Loss? Yes / No how much

Women: Possibility of pregnancy? Yes / No

Occupation:

Tobacco use? Yes / No #cans/packs per day:

Alcohol use: Yes / No How much/often:

Street drug use? Yes / No Drug Names:

Last use:

Caffeine use? Yes / No How much:

PERSONAL MEDICAL HISTORY: (Please indicate with a check whether you have had any of the following medical problems)

<u>Medical Condition</u>	<input checked="" type="checkbox"/>	<u>Medical Condition</u>	<input checked="" type="checkbox"/>	<u>Medical Condition</u>	<input checked="" type="checkbox"/>
Heart Problems		Ulcers		Thyroid/glandular problems	
Heart attack		Stroke		Cancer: Where	
Angina/Chest pain		Diabetes		Arthritis : Where	
Kidney problems		Stomach problems		Paralysis/weakness	
Breathing problems		High blood pressure		Problems with surgery	
Lung disease		Psychiatric/emotional		Osteoporosis	
Bleeding problems					

PAGE 2

FAMILY HISTORY: (Please indicate with a check family members who have had any of the following conditions)

Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives	Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives
Alcoholism								Genetic Diseases							
Anemia								Glaucoma							
Anesthesia Problem								Hearing problems							
Arthritis								Heart Attack (coronary Artery Disease)							
Asthma								High Blood Pressure							
Birth Defects								High Cholesterol							
Bleeding problems								Kidney diseases							
Cancer, Breast								Lupus							
Cancer, Colon								Migraine headache							
Cancer, Melanoma								Mirtal Valve Prolapse							
Cancer, Skin								Osteoarthritis							
Cancer, Ovary								Osteoporosis							
Cancer, Prostate								Rheumatoid Arthritis							
Cancer (not noted)								Stroke							
Depression								Thyroid disorders							
Diabetes, Type 1								Tuberculosis							
Diabetes, Type 2 (adult onset)								Epilepsy (seizures)							
Eczema								Other:							

Form completed by: