

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### MEDICAL HISTORY

Please select any problems you currently have or have had in the past.

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Aids/HIV            | <input type="checkbox"/> COPD                   | <input type="checkbox"/> Heartburn / reflux | <input type="checkbox"/> Rheumatoid arthritis             |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Depression             | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Seizure disorders                |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Hypertension       | <input type="checkbox"/> Stomach ulcer                    |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Drug abuse             | <input type="checkbox"/> High cholesterol   | <input type="checkbox"/> Stroke                           |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Fibromyalgia           | <input type="checkbox"/> Kidney disease     | <input type="checkbox"/> Thyroid problems                 |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Gout                   | <input type="checkbox"/> Liver disease      | <input type="checkbox"/> <b>NONE OF THESE APPLY TO ME</b> |
| <input type="checkbox"/> Blood clots         | <input type="checkbox"/> Heart disease / attack | <input type="checkbox"/> Osteoarthritis     |   |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart failure          | <input type="checkbox"/> Osteoporosis       |   |

### SURGICAL HISTORY

Please list all previous surgeries and the approximate year: ☐ **I HAVE NOT HAD ANY SURGERIES**

Surgery: _____	Year: _____	Surgery: _____	Year: _____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### FAMILY HISTORY

Does anyone in your immediate family (parents, brothers, sisters, children) have any of the following?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Ankylosing spondylitis | <input type="checkbox"/> Gout           | <input type="checkbox"/> Lupus                            |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Heart disease  | <input type="checkbox"/> Osteoarthritis                   |
| <input type="checkbox"/> Blood clots            | <input type="checkbox"/> Hypertension   | <input type="checkbox"/> Osteoporosis                     |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatoid arthritis             |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Liver disease  | <input type="checkbox"/> <b>NONE OF THESE APPLY TO ME</b> |

### SOCIAL HISTORY

**Hand Dominance:** ☐ Right ☐ Left ☐ Ambidextrous  
**How often do you exercise?** ☐ Never ☐ Occasionally ☐ Frequently ☐ Daily  
**Tobacco Use:** ☐ Yes ☐ No ☐ Former Year quit: \_\_\_\_\_ **Alcohol Use:** ☐ Yes ☐ No ☐ Former Year quit: \_\_\_\_\_  
 Type: ☐ Chewing ☐ Cigar ☐ Cigarette ☐ Pipe How often do you drink? ☐ Daily ☐ Weekly ☐ Monthly  
 Number of years used: \_\_\_\_\_ ☐ Rarely

### REVIEW OF SYSTEMS

Do you currently have any of these problems?

- |  |  |  |
|--|--|--|
| <b>Constitutional</b>  | <b>Cardiovascular</b>  | <b>Skin</b>  |
| Chills <input type="checkbox"/> Yes <input type="checkbox"/> No          | Chest pain <input type="checkbox"/> Yes <input type="checkbox"/> No          | Rash <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| Fever <input type="checkbox"/> Yes <input type="checkbox"/> No           | Irregular heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin infection <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| <b>HEENT</b>   | <b>Gastrointestinal</b>  | <b>Neurologic</b>  |
| Headache <input type="checkbox"/> Yes <input type="checkbox"/> No        | Abdominal Pain <input type="checkbox"/> Yes <input type="checkbox"/> No      | Difficulty walking <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No       | Heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No           | Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| <b>Respiratory</b>   | <b>Genitourinary</b>   | <b>Metabolic</b>   |
| Cough <input type="checkbox"/> Yes <input type="checkbox"/> No           | Frequent urination <input type="checkbox"/> Yes <input type="checkbox"/> No  | Cold intolerant <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| Short of breath <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood in urine <input type="checkbox"/> Yes <input type="checkbox"/> No      | Heat intolerant <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| <b>Psychiatric</b>   | <b>Hematologic</b>   | <b>Immunologic</b>   |
| Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No         | Easy bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No       | Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| Depression <input type="checkbox"/> Yes <input type="checkbox"/> No      | Easy bruising <input type="checkbox"/> Yes <input type="checkbox"/> No       | Environment allergy <input type="checkbox"/> Yes <input type="checkbox"/> No |

### SIGNATURE

To the best of my knowledge, the questions on this form have been answered accurately. It is my responsibility to inform the doctor of any changes in my medical status.

Signature of Patient (parent or guardian if the patient is a minor) \_\_\_\_\_

Date \_\_\_\_\_

**PATIENT INFORMATION**