

MEDICAL HISTORY

Name: _____ Date: _____

In order to provide you with the best possible care, we ask that you provide information regarding your medical history. Please answer “Yes” or “No” for each question. If you answer “Yes,” please explain by entering the details.

Musculoskeletal History

Please describe in-brief the medical problem for which you are consulting me. We will discuss this in-depth at your visit, so do not be concerned about the details.

YES NO Do you presently have any other bone, joint, muscle, or nerve problems other than the ones for which you are seeking consultation today?

YES NO Have you previously had any bone, joint, muscle, or nerve problems or injuries? If yes, please list problem(s) and approximate year(s):

Family History

Do any members of your immediate family (blood relatives) have:

YES NO Arthritis, gout, or any other bone, joint, muscle, or nerve problems (excluding traumatic injuries)? If yes, please describe:

YES NO Serious medical problems? If yes, please describe:

Systems Review

Do you have (if yes, please describe):

- YES NO Weight loss? _____
- YES NO Fevers? _____
- YES NO Frequent or severe headaches? _____
- YES NO Numbness or tingling? _____
- YES NO Double or blurry vision? _____
- YES NO Dizziness? _____
- YES NO Cough? _____
- YES NO Chest pain? _____
- YES NO Shortness of breath? _____
- YES NO Excessive bleeding when cut? _____
- YES NO Frequent nose bleeds? _____
- YES NO Nausea? _____
- YES NO Heartburn? _____
- YES NO Burning or pain with urination? _____
- YES NO Excessive or frequent urination? _____
- YES NO Skin rash? _____
- YES NO Swelling of feet or ankles? _____
- YES NO Depression? _____

General History

Have you ever had or been treated for, or do you now have: (if yes, please give details):

- YES NO Rheumatoid (inflammatory) arthritis? _____
- YES NO Lupus? _____
- YES NO Other collagen-vascular (auto-immune) disorders? _____
- YES NO Gout? _____
- YES NO Cancer? _____
- YES NO Osteoporosis or osteopenia? _____
- YES NO Vitamin D deficiency? _____
- YES NO Diabetes? _____
- YES NO Thyroid disorders? _____
- YES NO Other endocrine disorders? _____

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- YES NO Anemia? _____
- YES NO Sickle cell anemia? _____
- YES NO Bleeding disorders? _____
- YES NO Thrombophlebitis or blood clots? _____
- YES NO Other blood disorders? _____
- YES NO Dermatitis? _____
- YES NO Psoriasis? _____
- YES NO Other skin disorders? _____
- YES NO Glaucoma? _____
- YES NO Cataracts? _____
- YES NO Other eye problems? _____
- YES NO Deafness? _____
- YES NO Other ear, nose, or throat disorders? _____
- YES NO Epilepsy or seizures? _____
- YES NO Stroke? _____
- YES NO Concussion? _____
- YES NO Other neurologic disorders? _____
- YES NO Lyme disease? _____
- YES NO Hepatitis? _____
- YES NO Infectious mononucleosis? _____
- YES NO HIV infection? _____
- YES NO AIDS? _____
- YES NO Pneumonia? _____
- YES NO Other infectious diseases? _____
- YES NO Heart attack? _____
- YES NO Elevated cholesterol or triglycerides? _____
- YES NO High blood pressure? _____
- YES NO Rheumatic fever? _____
- YES NO Irregular heart beat? _____
- YES NO Heart murmur? _____
If yes, were you advised to take any medication? YES NO
- YES NO Other heart disorders? _____

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- YES NO Asthma? _____
- YES NO Emphysema? _____
- YES NO Other lung or breathing disorders? _____
- YES NO Reflux (“GERD”)? _____
- YES NO Ulcers of the stomach or intestine? _____
- YES NO Gall bladder disease? _____
- YES NO Liver disease? _____
- YES NO Other digestive disorders? _____
- YES NO Recurrent urinary tract infections? _____
- YES NO Other kidney, bladder or urine disorders? _____
- YES NO **Men:** Prostate disease? _____
- YES NO **Women:** Menopause? _____
- YES NO **Women:** Amenorrhea (absence of menstrual periods)? _____
- YES NO **Women:** Other gynecologic disorders? _____
- YES NO Eating disorders or anorexia nervosa? _____
- YES NO Bulimia? _____
- YES NO Persistent anxiety or nervousness? _____
- YES NO Persistent depression? _____
- YES NO Other persistent psychological disorders? _____
- YES NO Have you received immunizations for tetanus?
Date of last booster shot: _____ (Booster shot is required every 10 years)
- YES NO Have you had **surgery not described anywhere above?**
If yes, please list type of surgery (including side of body) and year:

YES NO Have you been treated for or do you now have other **illnesses or injuries** not described anywhere above? If yes, please give details:

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YES NO Do you have any dietary or nutritional restrictions? If yes, please give details:

YES NO Do you smoke cigarettes, cigars, or a pipe, or use e-cigarettes or a vaporizer? If yes, indicate type and amount:

Medications, Supplements, Allergies

YES NO Do you have an **allergy** to latex?

YES NO Do you have any **allergies** to any drugs, medications, or other items? If yes, please list items (and reactions, if known):

YES NO Do you take any prescription medications? If yes, please list:

<u>Name of medication</u>	<u>Dose (mg, times per day)</u>	<u>What the medication treats</u>
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YES NO Do you take any “over-the-counter” medications or pills (including herbals and supplements)? If yes, please list:

<u>Name of medication/supplement</u>	<u>Dose (mg, times per day)</u>	<u>What the medication treats</u>
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Health Care Providers

Pharmacy We must submit all prescriptions electronically. If you do not have a pharmacy, please select one near your home or work and enter the information.

Pharmacy name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Physician I don't have one Enter your internist, family practitioner, or gynecologist (*etc.*):

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

YES NO Are you presently under the care of any other physicians or health care providers (medical specialist, podiatrist, chiropractor, *etc.*)? If yes, enter:

Name: _____ Phone: _____

Specialty of provider: _____

Address: _____

City: _____ State: _____ Zip: _____

Name: _____ Phone: _____

Specialty of provider: _____

Address: _____

City: _____ State: _____ Zip: _____

Other information that you would like to provide:

I have answered all the above questions completely and truthfully, to the best of my knowledge. I authorize review of my medical information in electronic systems, including but not limited to EPIC and the Health Information Exchange. If I file an insurance claim, I authorize the release of any medical or other information necessary to process the claim.

Patient's Signature

Date