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:

MEDICAL HISTORY Name: _____ Date: _____

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? _____

MEDICAL HISTORY

Name: _____ Date: _____

☐ 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 trigylcerides? _____

☐ 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? _____

MEDICAL HISTORY

Name: _____ Date: _____

☐ 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:

MEDICAL HISTORY Name: _____ Date: _____

☐ 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:

Name of medication	Dose (mg, times per day)	What the medication treats

☐ YES ☐ NO Do you take any "over-the-counter" medications or pills (including herbals and supplements)? If yes, please list:

Name of medication/supplement	Dose (mg, times per day)	What the medication treats

MEDICAL HISTORY Name: _____ Date: _____

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

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

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