# MEDICAL HISTORY FORM

PATIENT NAME________________________________ DATE OF BIRTH____________________
TODAY'S DATE________________________________

Describe what brings you to the office today_________________________________

_____________________________________________________________________________

Where is the problem located?________________________________________________
How long has it bothered you?________________________________________________
Does anything make it better or worse?_______________________________________
Was this caused by an injury or work related (circle one)
Describe_____________________________________________________________________

Do you have or ever been treated for:

____Alzheimer's ____Anemia ____Asthma
____Blood Disorders ____Bone Spurs ____Cancer type_________
____Chest Pain ____Colitis ____Diabetes
____Epilepsy ____Fibromyalgia ____Fractures of the foot
____Gout ____Heart Attack ____Heart conditions
____Hemophilia ____Hepatitis ____Hernia type_________
____HIV(human immune virus) ____High Blood Pressure
____Joint Swelling ____Keloid/thick scar ____Kidney Disease
____Leg Cramps ____Liver disease ____Low back pain
____Neuritis ____ Osteoarthritis ____Osteoporosis
____Phlebitis ____ Poor circulation ____Psychiatric Disorder
____Rheumatoid Arthritis ____Sciatica ____Shortness of breath
____Sickle Cell Anemia ____ Skin Condition ____Stroke
____Tarsal or Carpal tunnel syndrome

Any other problems not listed:_______________________________________________

_____________________________________________________________________________

Have you ever had surgery: yes or no
What type and what year?_____________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________
Social History: Do you use tobacco products?_________________________________

How much and what type do you use?___________________________________________

Do you drink alcohol?____________________ How much?__________________________

Women: # of childbirths_____________ Are you currently pregnant?_____________

**Are you presently taking medication? How Long? Please list below.**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Allergies or Reactions Please check all that apply and list reaction**

| Medication | Reaction |
|---|---|
| Penicillin__________________ | ____________________________________________ |
| Keflex______________________ | ____________________________________________ |
| Sulfa ______________________ | ____________________________________________ |
| Other Antibiotics___________ | ____________________________________________ |
| Morphine____________________ | ____________________________________________ |
| Codeine_____________________ | ____________________________________________ |
| Demerol_____________________ | ____________________________________________ |
| Darvon______________________ | ____________________________________________ |
| Vicodin_____________________ | ____________________________________________ |
| Lorcet______________________ | ____________________________________________ |
| Aspirin_____________________ | ____________________________________________ |
| Tylenol_____________________ | ____________________________________________ |
| Other Pain Medication_______ | ____________________________________________ |
| Mortin/Advil________________ | |
| Anti-Inflammatory Medication | ____________________________________________ |
| Celebrex/Bextra_____________ | ____________________________________________ |
| Local Anesthetics___________ | ____________________________________________ |
| Adhesive Tape_______________ | ____________________________________________ |
| Other_______________________ | ____________________________________________ |