Medical History

Name: _____

I understand that honest and complete answers to each question stated below are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.

DRUG HISTORY

A. Please list all medications you are CURRENTLY taking regularly (including "over-the-counter" medications and health food store remedies). Please indicate the approximate time you have taking them.

Check if none ☐

Drug:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

MEDICAL HISTORY

Check boxes only if condition applies.

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

( ) ADD	( ) Cardiac arrhythmia	( ) Ehlers-Danlos syndrome	( ) Hypothyroidism
( ) Alzheimer's Disease	( ) Carpal tunnel		( ) IBS
( ) Anemia	( ) Cerebral palsy	( ) Emphysema	( ) Immune disease
( ) Anxiety disorder	( ) Chest pain	( ) Epilepsy	( ) of any type
( ) Arthritis (Rheumatoid)	( ) CHF	( ) Fainting spells	( ) Keloids
( ) Arthritis	( ) Chronic diarrhea	( ) Fibromyalgia	( ) Kidney disease
( ) (Wear and Tear)	( ) Chronic pancreatitis	( ) Gastroesophageal	( ) Liver disease
( ) Asthma	( ) Crohn's disease	( ) reflux disease	( ) Melanoma
( ) Atrial fibrillation	( ) Clotting disorder	( ) Gout	( ) Mitral valve prolapse
( ) Avascular necrosis	( ) Dementia	( ) Heart attack	( ) Multiple sclerosis
( ) Back pain	( ) Depression	( ) Heart disease	( ) Neurological disorder
( ) Bakers cyst	( ) Diabetes	( ) Heart murmur	( ) Neuropathy
( ) Berger's disease	( ) Lupus	( ) Heart problems	( ) Osteoporosis
( ) Blood disease	( ) Diverticulitis	( ) Hepatitis	( ) Pacemaker
( ) Blood thinners	( ) Down's syndrome	( ) High blood pressure	( ) Parkinson's disease
( ) Cancer	( ) Eczema	( ) HIV	( ) Peptic ulcer disease

Patient Initials _____

Medical History

Check boxes only if condition applies.

( ) Peripheral neuropathy
( ) Peripheral vascular disease
( ) Polio
( ) Poor circulation
( ) Currently pregnant or nursing
( ) Prolonged bleeding
( ) Psoriasis
( ) Pulmonary embolism
( ) PVD
( ) Raynaud's syndrome
( ) Reiter's syndrome
( ) Restless leg syndrome
( ) Rheumatic fever
( ) RSD/CRPS
( ) Sarcoidosis
( ) Scleroderma
( ) Seizures
( ) Shingles
( ) Shortness of breath
( ) Sickle cell
( ) Skin cancer
( ) Skin disease
( ) Spina bifida
( ) Spinal stenosis
( ) Stomach ulcer
( ) Stomach or intestinal problems
( ) Stroke
( ) Tendonitis
( ) Thyroid disease
( ) Trigger finger
( ) Ulcerative colitis
( ) Vertigo
( ) Warts

ALLERGIES

B. Please list any drugs you are **ALLERGIC** to or have had a significant reaction or intolerance.

Check if none ☐

Drug:

Drug:

SURGERIES

C. List all SURGERIES you have had (youngest to oldest)

Check if none ☐

Surgery

Age

Medical History

FAMILY HISTORY

Please indicate which of the following run in your family and their relation to you.

Medical Condition:	Deceased	Alive	Relation:
Heart disease	☐	☐	_____
Cancer	☐	☐	_____
High blood pressure	☐	☐	_____
Diabetes	☐	☐	_____
Kidney disease	☐	☐	_____
Rheumatoid arthritis	☐	☐	_____
Neurological disease	☐	☐	_____
Sickle Cell	☐	☐	_____
Gout	☐	☐	_____
Psoriasis	☐	☐	_____

SOCIAL HISTORY

A. **Check the highest level of education completed:**
□ Grade School □ High School □ Partial College □ College Graduate □ Professional School

B. **What is your current occupation?** _____

C. **Shoe Size:** _____

D. **Height:** _____

E. **Weight:** _____

F. **Blood Pressure:** _____

G. **Are you a?**
☐ Current Smoker
☐ Former Smoker
☐ Never Smoker
☐ Current every day smoker
☐ Current some day smoker
Do you use any other tobacco products? Yes or No

	YES	NO	
H.	☐	☐	Do you consume any alcoholic beverages (including beer, wine coolers, etc.)? What? _____ How much and how often? _____
I.	☐	☐	Have you ever had to go through rehabilitation for drinking?
K.	☐	☐	Have you ever been poisoned or chronically exposed to any toxin? If YES, please name the toxin & length of exposure. _____

Medical History

REVIEW OF SYSTEMS

CONSTITUTIONAL
( ) Fever on a regular basis
( ) Night sweats
( ) Fatigue
( ) Swollen glands
( ) Loss of appetite
( ) Insomnia
( ) Weakness
( ) Weight loss in 6 months more than 10 lbs.
( ) Weight gain in 6 months more than 10 lbs.

MUSCULOSKELETAL
( ) Morning stiffness in hands
( ) Swelling in joints
( ) Swelling in feet, ankles, or legs
( ) Joint aches and pains that come and go
( ) Muscle cramps and tenderness
( ) Aching pain in buttocks, thighs, or calves when walking

EAR, NOSE, AND THROAT
( ) Hearing loss
( ) Ringing in ears

OPTHAMOLOGY
( ) Vision loss
( ) Glasses or contacts

RESPIRATORY
( ) Shortness of breath
( ) Chest pains
( ) Chronic cough

CARDIOLOGY
( ) Chest pain
( ) Palpitations
( ) Leg swelling
( ) Shortness of breath

GASTROENTEROLOGY
( ) Nausea
( ) Heart burn
( ) Vomiting
( ) Diarrhea
( ) Difficulty swallowing
( ) Constipation
( ) Change in bowel habits
( ) Blood in stools
( ) Abdominal pain

DERMATOLOGY
( ) Rash
( ) Hives
( ) Raynaud's
( ) Alopecia
( ) Psoriasis
( ) Eczema

NEUROLOGY
( ) Headaches
( ) Tingling in
  ( ) Arms
  ( ) Legs
  ( ) Feet
( ) Weakness in
  ( ) Arms
  ( ) Legs
  ( ) Feet
( ) Numbness
  ( ) Arms
  ( ) Legs
  ( ) Feet
( ) Frequently falling
( ) Stumbling
( ) Tripping
( ) Dizziness
( ) Tremors
( ) Restless leg syndrome
( ) Peripheral Neuropathy
( ) Memory loss
( ) Seizures

UROLOGY
( ) Frequent urination
( ) Bloody or cloudy urine
( ) Painful urination

ENDOCRINOLOGY
( ) Excessive sweating
( ) Excessive thirst
( ) Excessive urination
( ) Cold intolerance
( ) Heat intolerance

PSYCHOLOGY
How would you describe yourself?
( ) Calm
( ) Nervous
( ) Depressed
( ) Moody
( ) Angry
( ) Fearful
( ) Happy

Have you ever received psychiatric or psychological counseling?
( ) Yes
( ) No