

Adult Medical History Form

Name (print): _____ Sex: M / F Today's Date: _____
 Phone: _____ Date of Birth: _____ Age: _____ Height/Weight _____
 Name of your Primary Care Doctor: _____ Phone: _____
 Were you referred by a physician? **Y / N** Name: _____ Phone: _____

1. Reason for today's visit: (indicate **BODY PART**, briefly state history of the problem and when the symptoms began): **Left or Right** (circle) _____

2. Have you ever had a similar problem or injury to the area/region being assessed today? (explain) _____
Is this a re-injury? (circle) Y / N

3. Problem is due to: (check) ___ Car Accident ___ Work Related ___ School Injury ___ Other

4. Have you ever had previous bone, joint or nerve problems previously? (circle) Y / N (explain) _____

5. Do you have any medical devices implanted in your body? (pacemaker, portacath, pump, rods, prosthesis, etc.) _____

6. Are you currently under treatment for any medical condition? (list condition and treatment) _____

7. Medications: (list name(s) and dosage(s), including any blood thinners and over the counter medications)

Medicine	Dose	# per day	Medication	Dose	# per day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

8. Allergies (medicines, **LATEX**): _____

9. Do you have any unusual allergies/reactions to medications? (describe) _____

***If you are a prior patient and have been treated within the past year you must sign the disclaimer below indicating that there have not been any changes to your medical history.*
****If there have been changes to your medical history, bypass this disclaimer and indicate all changes.*
DISCLAIMER: I confirm that there have NOT been any changes in my medical history since the last date of registration.
Signature: _____ **Date:** _____

Prior History: (list all surgeries, major illnesses, injuries and hospitalizations with dates)

Date	Surgery / Major Illness / Injury	Hospitalized
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History: Occupation - _____ **Are you working now?** Yes / No / Retired
Are you (circle one) Single / Married / Legally Separated / Divorced / Widowed **Live alone?** Yes / No
Do you have children? Yes / No **How Many?** _____ **Ages** _____
Do you have a health care proxy? (if Yes, who)? _____
Are you on a special diet?(explain) _____
Do you exercise / play sports / hobbies (describe briefly)? _____
Do you smoke? Yes / No / Quit Packs per day _____ If quit, years smoked: _____ yrs.
Alcohol use (circle one): Never / Occasional / Daily / Heavy / History of alcoholism
 Any history of **Drug use** (list): _____
 Are you presently going to school? Y / N Education Level K 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4

PLEASE COMPLETE REVERSE SIDE

Name (print): _____ Date of Birth: _____

Review of Symptoms: Are you currently having problems with any of the following? (circle all that apply)

EYES:
 Glasses
 Cataracts
 Glaucoma
 Other _____

SKIN:
 Dermatitis
 Rashes
 Psoriasis
 Eczema
 Other _____

EAR/NOSE/THROAT:
 Deafness
 Allergies
 Sinus Trouble
 Nosebleeds
 Chronic Sinus Infection
 Trouble Swallowing
 Other _____

NEUROLOGIC:
 Stroke
 Seizures
 Dizziness
 Multiple Sclerosis
 Numbness/Tingling
 Parkinson's
 Fainting
 Backouts/Falls
 Other _____

INFECTIOUS DISEASE:
 HIV
 Hepatitis
 Lyme Disease
 Positive TB test
 Other _____

**HEART AND
 CARDIOVASCULAR:**
 Chest Pain
 Heart Attack
 Palpitations
 Heart Disease
 Circulation problems
 Blood Pressure HI/LOW
 Blood Clots
 Arrhythmia

CARDIOVASCULAR:
 Varicose Veins
 Rheumatic Fever
 Heart Murmur
 Pulmonary Embolus
 Other _____

ENDOCRINE:
 Diabetes
 Thyroid Disease
 Other _____

GENITOURINARY:
 Bladder Infection
 Kidney Disease
 Incontinence
 Kidney Infection
 Kidney Stones
 Frequent Urination
 Painful Urination
 Bloody Urine
 Frequent Nighttime Urination
 Prostate Problem
 Other _____

PULMONARY/RESPIRATORY:
 Asthma
 Emphysema
 Bronchitis
 Pneumonia
 Wheezing
 Shortness of Breath
 Sleep Apnea
 Other _____

HEMOTOLOGIC/LYMPHATIC:
 Lymphedema
 Anemia
 Sickle Cell
 Easy Bleeding
 Transfusion
 Abnormal Bruising
 Blood Disorder
 Other _____

PSYCHOLOGIC:
 Depression
 Anxiety
 Bipolar Disorder
 Other _____

GASTROINTESTINAL:
 Ulcers
 Reflux
 Crohn's
 Nausea
 Vomiting
 Diarrhea
 Constipation
 Bloody/Black Bowel Movement
 Abdominal Pain
 Liver Disease
 Jaundice
 Other _____

CONSTITUTIONAL:
 Fever
 Weight Loss
 Loss of Appetite
 Night Sweats
 Fatigue
 Chills
 Other _____

ONCOLOGIC:
 Cancer
 Type _____

MUSCULOSKELETAL:
 Rheumatoid Arthritis
 Osteoporosis
 Joint Pain
 Back Pain
 Neck Pain
 Slipped Disc
 Leg Pain
 Joint Stiffness/Swelling
 Gout
 Other _____

OB/GYN
 Pregnant Now? **Y / N**
 Other _____

Cont. HEART AND

Comments: _____

Family Medical History: List medical problems of your relatives (ex. diabetes, cancer):

Grandparents: _____
 Mother: _____ Father: _____
 Siblings: _____
 Children: _____