

# PATIENT MEDICAL HISTORY FORM

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Referring Physician (name, address and phone number): \_\_\_\_\_

Present Complaint: Rt Lt (indicate body part) \_\_\_\_\_

Date of Onset: \_\_\_\_\_ Injury Related: ( ) Yes ( ) No Work Related: ( ) Yes ( ) No

List activities that make it worse: \_\_\_\_\_

Previous treatment (therapy, injections, medications): \_\_\_\_\_

When: \_\_\_\_\_

Treating Physician(s) (name, address, and phone number): \_\_\_\_\_

## Review of Systems (Circle any symptoms you experience regularly): ( ) None

Weight Loss	Poor Vision	Tingling	Vertigo
Weight Gain	Hearing Loss	Tremors	Muscle Weakness
Fatigue	Ringing in Ears	Rashes	Joint Stiffness
Fever	Upset Stomach	Open Sores	Back Pain
Chills	Constipation	Excessive Thirst	Other: _____
Cough	Bloody Stools	Frequent Urination	_____
Shortness of Breath	Diarrhea	Painful Urination	_____
Chest Pain	Easy Bruising	Hair Loss	Other joint pain: _____
Palpitations	Easy Bleeding	Mood Swings	_____
Leg Swelling	Poor Balance	Anxiety	_____
Blurred Vision	Numbness	Depression	_____

## Medications, Vitamins or Supplements & Dosages: ( ) None

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Allergies to Medications: ( ) None:

Other Allergies: Metal, Iodine, Shellfish

## Social History:

Do you smoke? ( ) Yes ( ) No If yes, : \_\_\_\_\_ packs per day for \_\_\_\_\_ years

Do you drink alcohol? ( ) Yes ( ) No If yes, how much? \_\_\_\_\_

Occupation: \_\_\_\_\_

Where do you live: (Circle One) Home Apartment Retirement Community

Who do you live with: \_\_\_\_\_

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**Family History:** Is there any family history of: (Circle): ( ) **None**  
Stroke Heart Disease Diabetes Cancer Arthritis Other: \_\_\_\_\_

If Yes, Please explain: \_\_\_\_\_

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**Past Medical History: Do you have currently or have you ever had?**

Anemia:	( ) Y ( ) N	Elevated Cholesterol:	( ) Y ( ) N	Liver Disease/hepatitis:	( ) Y ( ) N
Angina:	( ) Y ( ) N	Emphysema/COPD:	( ) Y ( ) N	Pancreatis:	( ) Y ( ) N
Asthma:	( ) Y ( ) N	Epilepsy:	( ) Y ( ) N	Pneumonia:	( ) Y ( ) N
Atrial Fibrillation:	( ) Y ( ) N	Fractures:	( ) Y ( ) N	Hiatal Hernia/Reflux:	( ) Y ( ) N
Bladder Infection:	( ) Y ( ) N	Glaucoma:	( ) Y ( ) N	Sinus Problems:	( ) Y ( ) N
Bronchitis:	( ) Y ( ) N	Gout:	( ) Y ( ) N	Sleep Apnea:	( ) Y ( ) N
Cancer:	( ) Y ( ) N	Heart Attack:	( ) Y ( ) N	Stomach Ulcers:	( ) Y ( ) N
Cellulitis:	( ) Y ( ) N	Heart Arrhythmia:	( ) Y ( ) N	Stroke:	( ) Y ( ) N
Congestive Heart Failure:	( ) Y ( ) N	Heart Valve Disease:	( ) Y ( ) N	Thyroid Disorders:	( ) Y ( ) N
Coronary Artery Disease:	( ) Y ( ) N	High Blood Pressure:	( ) Y ( ) N	TIA:	( ) Y ( ) N
Depression:	( ) Y ( ) N	HIV:	( ) Y ( ) N	Blood clots:	( ) Y ( ) N
Diabetes:	( ) Y ( ) N	Kidney Disease:	( ) Y ( ) N	Osteoarthritis:	( ) Y ( ) N
Dialysis:	( ) Y ( ) N	Kidney Stones:	( ) Y ( ) N	Rheumatoid Arthritis:	( ) Y ( ) N
Diverticulitis:	( ) Y ( ) N	Leukemia:	( ) Y ( ) N	Osteoporosis:	( ) Y ( ) N

Other: \_\_\_\_\_

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**Past Surgical History:** Please mark all previous surgeries: ( ) **None**

( ) C-section ( ) Cataract surgery ( ) Hernia repair ( ) Hysterectomy ( ) Pacemaker ( ) Tonsils ( ) Gall bladder  
( ) TURP ( ) Appendectomy ( ) Arthroscopy ( ) Thyroid ( ) Mastectomy ( ) Hip pinning ( ) Cosmetic surgery  
( ) Right total knee replacement ( ) Left total knee replacement ( ) Repeat Right knee replacement ( ) Repeat  
Left knee replacement  
( ) Right partial knee replacement ( ) Left partial knee replacement  
( ) Right total hip replacement ( ) Left total hip replacement ( ) Repeat Right hip replacement ( ) Repeat Left hip  
replacement  
Other surgery:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Problems with anesthesia: ( ) Yes ( ) No explain: \_\_\_\_\_

Problems with Foley/Bladder catheter: ( ) Yes ( ) No explain: \_\_\_\_\_

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Elaborate on medical history/medications if necessary (use separate sheet if necessary):  
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\_\_\_\_\_  
\_\_\_\_\_

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Primary Care Physician: (name, address and phone number) \_\_\_\_\_

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