

# MEDICAL HISTORY

(update 2010)

## **PLEASE COMPLETE THIS FORM BEFORE YOUR OFFICE VISIT**

Please answer all questions. If you do not know the answer or do not understand the question, insert a question mark in the space. Please **do not leave the space blank**

**Reason for your visit today:** \_\_\_\_\_

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
DOB \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

### **Primary Health Care Provider (Doctor, Pa, Np):**

1. \_\_\_\_\_ Approximate date of last visit: \_\_\_\_\_  
2. \_\_\_\_\_ Reason for last visit: Annual  Other \_\_\_\_\_  
Date of last EKG: \_\_\_\_\_ Where? \_\_\_\_\_ Recent lab tests: \_\_\_\_\_ Where? \_\_\_\_\_  
Date of last Chest XRay: \_\_\_\_\_ Where? \_\_\_\_\_ Any abnormal findings? \_\_\_\_\_

### **ALLERGIES** **No Known Allergies**

Please list all medications and substances to which you are allergic and the type of reaction you have to the substance.

<u>Allergy</u>	<u>Effect</u>	<u>Allergy</u>	<u>Effect</u>
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Do you have an allergy to latex? \_\_\_\_\_ Do you have an allergy to tape or adhesives? \_\_\_\_\_  
Has a blood transfusion caused a bad reaction? \_\_\_\_\_

**Past Medical History** – List all current medical problems (for example, high blood pressure, ulcers, diabetes) **and** list the treating provider if other than your primary provider.

1. \_\_\_\_\_ 5. \_\_\_\_\_  
2. \_\_\_\_\_ 6. \_\_\_\_\_  
3. \_\_\_\_\_ 7. \_\_\_\_\_  
4. \_\_\_\_\_ 8. \_\_\_\_\_

List all hospitalizations, **excluding surgeries**.

<u>Problem</u>	<u>Date</u>	<u>Hospital/City</u>	<u>Provider</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

**Past Surgical History** – List all operations, the dates (most recent first), and the surgeon.

1. \_\_\_\_\_ 4. \_\_\_\_\_  
2. \_\_\_\_\_ 5. \_\_\_\_\_  
3. \_\_\_\_\_ 6. \_\_\_\_\_

Have you or any family member had problems with anesthesia? \_\_\_\_\_

### **Current Medications**

Be sure to list all the drugs you take, including aspirin, pain medications, hormones, contraceptives, sleeping pills, over-the-counter.

<u>Medication</u>	<u>Strength</u>	<u>Taken how often</u>	<u>Medication</u>	<u>Strength</u>	<u>Taken how often</u>
1. _____	_____	_____	5. _____	_____	_____
2. _____	_____	_____	6. _____	_____	_____
3. _____	_____	_____	7. _____	_____	_____
4. _____	_____	_____	8. _____	_____	_____

Have you ever used steroid medications (cortisone, prednisone, etc)? \_\_\_\_\_

If yes, what is the reason for the steroid treatment? \_\_\_\_\_

**Family Health**

Have any blood relatives ever had any of the following? If so, indicate their relationship to you.

Diabetes \_\_\_\_\_ Arthritis \_\_\_\_\_  
High blood pressure \_\_\_\_\_ Cancer (type) \_\_\_\_\_  
Heart disease \_\_\_\_\_ Blood disease \_\_\_\_\_  
Liver disease \_\_\_\_\_ Psychiatric disease \_\_\_\_\_  
Kidney disease \_\_\_\_\_ Blood clots \_\_\_\_\_ Stroke \_\_\_\_\_  
Lung disease \_\_\_\_\_ Back disorder \_\_\_\_\_

If your mother, father, or any of your brothers and/or sisters have died, what was the cause of death and the age at the time of death? \_\_\_\_\_

**Social History**

Marital status: Single Married Partner Widowed Divorced  
Number of children \_\_\_\_\_ Do you have someone to assist you at home? Who? \_\_\_\_\_  
Work status: Unemployed/Disabled Retired Part time Job Title \_\_\_\_\_ Full time  
If working, what is your job title? \_\_\_\_\_  
Do you have an active lifestyle? \_\_\_\_\_ If yes, what is the activity? \_\_\_\_\_  
Do you drink alcohol? \_\_\_\_\_ If so, how much/ frequency \_\_\_\_\_  
Do you use tobacco? \_\_\_\_\_ If so, how much and how long OR when did you quit? \_\_\_\_\_

**Review Of Systems**--Please read each list of symptoms below. Do you have, or have you ever had any of these symptoms? If so, please circle the symptoms that you have experienced.

**General**

- recent weight loss
- recent weight gain
- recent fever or chills
- fatigue / feeling tired often
- change in appetite
- change in sleep pattern

**Respiratory**

- sleep apnea
- pneumonia
- pleurisy
- tuberculosis
- asthma / wheezing
- chronic bronchitis
- emphysema
- coughing up blood
- sinus infections

**Circulatory/cardiac (heart)**

- heart attack
- heart trouble
- murmur
- palpitations
- chest pain, heaviness
- heart failure / CHF
- high blood pressure / hypertension
- valve problems
- rheumatic fever
- high cholesterol
- varicose veins
- swelling of both ankles
- calf pain when walking

**Digestive**

- ulcer
- heartburn
- special diet

- difficulty swallowing
- hiatal hernia
- inguinal or umbilicus hernia
- jaundice
- vomiting of blood
- bloody stools
- liver trouble
- gallbladder trouble
- persistent diarrhea
- constipation
- irritable bowel syndrome
- diverticulosis / diverticulitis
- other digestive disorder \_\_\_\_\_

**Endocrinology**

- hormone problem
- night sweats
- thyroid problem
- diabetes

**Skin**

- recent rashes
- difficulty healing wound
- any resistant infection /MRSA or VRE

**Hematology**

- anemia
- platelet problem
- blood clotting disorder
- bleeding
- bruising tendency
- cancer
- radiation therapy
- phlebitis
- blood clots (DVT)
- frequent bloody nose
- bleeding gums

**Genitourinary**

- abnormal urine tests
- bladder infection
- kidney disease
- kidney stones
- venereal disease
- STD(sexually transmitted disease)
- frequent nighttime urination
- reaction to IVP dye
- MALE: prostate trouble
- FEMALE: Breast tumor or cyst
- Currently Pregnant
- Last period \_\_\_\_\_

**Neurological**

- numbness
- tingling
- weakness
- frequent headaches
- seizures
- loss of consciousness
- stroke
- paralysis
- tremors
- sudden visual changes
- speech changes
- depression
- anxiety
- psychiatric condition
- other neurologic disease

**Musculoskeletal**

- stiff neck
- back pain
- diabetic ulcers
- other extremity problems

Print Name \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Provider Initials

Date

Name \_\_\_\_\_

Date \_\_\_\_\_

### PHYSICAL EXAM CHECK LIST

Height / weight: see top of medical history form

VITAL SIGNS: BP \_\_\_\_\_ Pulse \_\_\_\_\_  
R \_\_\_\_\_ Temp \_\_\_\_\_

CONSTITUTIONAL

General appearance: WNWD  NAD

SKIN

Inspection WNL  Op site WNL

EYES

Eye glasses yes  no   
Conjunctivae/lids WNL  deferred   
PERRLA WNL  deferred   
EOM WNL  deferred   
Fundi WNL  deferred

ENMT

Ears/canals/TMs WNL  deferred   
Hearing aids yes  no   
Nose WNL  deferred   
Oropharynx WNL  deferred   
Dentures yes  no

NECK

Carotids / bruits WNL  deferred   
Thyroid WNL  deferred   
Masses WNL  deferred   
Lymph WNL  deferred

CARDIOVASCULAR

Heart auscultation WNL  deferred   
Abdominal aorta WNL  deferred   
Femoral arteries WNL  deferred   
Pedal pulses WNL  deferred   
Affected extrm pulses WNL  deferred   
Extrm edema/varicosities WNL  deferred

RESPIRATORY

Respiratory effort WNL  deferred   
Lung auscultation WNL  deferred

ABD/GI

Masses/tenderness WNL  deferred   
Liver/spleen WNL  deferred   
Hernia presence WNL  deferred   
Bowel sounds WNL  deferred   
Bruits / palpable pulse WNL  deferred   
CVA tenderness WNL  deferred

LYMPH

Neck WNL  deferred   
Axillae WNL  deferred   
Groin WNL  deferred   
Other WNL  deferred

NEURO

Cranial nerves WNL  deferred   
DTR's WNL  deferred   
Sensation WNL  deferred   
Mental Status WNL  deferred   
Strength testing WNL  deferred

ORTHO/MUSCULOSKELETAL

PREOPERATIVE CHECKLIST

Needs medical clearance

LABS

CBC BMP H&H  
CMP PT/INR UA  
Type and screen Type and cross match

RADIOLOGY

CXR XRAY \_\_\_\_\_  
MRI \_\_\_\_\_  
Other \_\_\_\_\_  
ECG \_\_\_\_\_

Surgery date /Where?: \_\_\_\_\_

H&P dictated

Date \_\_\_\_\_ Initial \_\_\_\_\_

Please fill out the appropriate information below if you have had any of the procedures, specifically if related to your back or neck problem.

Procedure	Hospital/clinic	When
X-rays	_____	_____
MRI scan	_____	_____
CAT scan	_____	_____
CT Myelogram	_____	_____
Bone Scan	_____	_____
Bone Density	_____	_____
Nerve study/EMG	_____	_____
Injections:	_____	_____
Epidural / steroids	_____	_____

Therapies:	What medication?	Helpful?
Anti-inflammatories	_____	_____
Pain meds / narcotics	_____	_____
Muscle relaxants	_____	_____
Antidepressants	_____	_____
Oral steroids	_____	_____

Other Therapies	Helpful?
Physical therapy	_____
Occup therapy	_____
Water therapy	_____
Chiropractor	_____
Osteop manipulations	_____
Pain clinic/program	_____
Back school	_____
Exercise	_____
Brace	_____
TENS unit	_____

Please mark these drawings according to where you have pain (if the back of your neck hurts, mark the drawing on the back of the neck). If you feel any of the following symptoms, please indicate which sensations you feel by placing the marks shown below.

▲▲▲ Aching      000 Pins & Needles  
 XXX Burning      VVV Numbness  
 /// Stabbing      ●●● Other

RIGHT

LEFT

**FRONT**

LEFT

RIGHT

**BACK**