



Medical History

Patient First Name: _____ Patient Last Name: _____

Height: _____ Weight: _____ Pain Level (0-10): _____

MEDICATIONS Please list all medications and dosages OR give a list to the front desk:

| Medication Name: | Dosage | Medication Name: | Dosage |
|------------------|--------|------------------|--------|
| 1. | | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

ALLERGIES

_____ No known drug allergies **OR**

Please list any allergies with reaction below:

| Drug/Environmental/Food Allergy: | Reaction: |
|----------------------------------|-----------|
| | |
| | |

PERSONAL MEDICAL HISTORY Check those that apply to you now or have applied to you in the past:

| | |
|--|------------------------------|
| Diabetes: Average Blood Sugar: _____ Last A1C: _____ | Multiple Sclerosis |
| Peripheral Neuropathy | Raynaud's Syndrome |
| Celiac Disease | Sexually Transmitted Disease |
| Liver Disorder | Drug/Alcohol Abuse |
| Kidney Disease | Epilepsy or Seizures |
| Dialysis | Stomach/Ulcer Disorder |
| Frequent Headache/Migraines | Thyroid/Parathyroid Disease |
| Asthma | High Blood Pressure |
| Emphysema | Arthritis |
| Heart Trouble | Psychiatric Treatment |
| Stroke | Difficulty Healing |
| Gout | Hepatitis/HIV |
| Blood clots | Anemia/Blood Disorders |
| Ear, Nose, Throat Disorder | Other: |

SURGICAL HISTORY

| Surgical Procedure | Year | Physician | Hospital |
|--------------------|------|-----------|----------|
| | | | |
| | | | |
| | | | |
| | | | |

FAMILY HISTORY

Has any **family member** had any of the following (please indicate relationship):

| | |
|-----------------|----------------------|
| Cancer: | Diabetes: |
| Heart Trouble: | High Blood Pressure: |
| Kidney Disease: | Bleeding Disorders: |
| Stroke: | Blood Clots: |
| Arthritis: | Other: |

SOCIAL HISTORY

Do you smoke currently? Yes No If yes, how much per day? _____

Do you drink alcohol? Yes No If yes, what and how often? _____

Do you use recreational drugs? Yes No

Are you currently experiencing any of the following? Check all that apply:

- Constitutional:** Weight Loss Fever /Chills
- Eyes:** Visual changes
- Ears, Nose, Mouth, and Throat:** Hearing loss
- Cardiovascular:** Chest pain Varicose veins Peripheral edema.
- Respiratory:** Cough Shortness of Breath Wheezing
- Gastrointestinal:** Abdominal pain Heartburn
- Genitourinary:** Frequent urination
- Musculoskeletal:** Joint Pain Joint Swelling
- Integumentary:** Rashes Sores Blisters
- Neurological:** Numbness Tingling Burning
- Psychiatric:** Anxiety Depression
- Endocrine:** Heat/cold intolerance
- Hematologic/Lymphatic:** Abnormal bleeding
- Allergic/Immunologic:** Recurrent infections