MEDICAL HISTORY

Today's Date: ______________________ Doctor You Are Seeing: ____

Patient Name: ______________________________________ DOB: _______________ Age: _________ ☐ Male ☐ Female

Briefly Describe Your Symptoms/Injury: ____

____

List Medications You Take Regularly: ____

____

____

MEDICATION ALLERGIES: ____

Describe Reactions: ____

Do You Smoke ☐Y ☐N How Many Per Day? ______________

Do You Drink Alcohol ☐Y ☐N Drinks per Week: _________________

Do You Use Illicit Drugs ☐Y ☐N

Date of Last Physical: ___________________________ Done By: ____

Did Physical Include: Chest X-ray ☐ EKG ☐ Blood Work ☐

Have You Ever Received Blood? ________________ When? _____________________ For? _____________________

Have You Ever Had:

☐ Anemia ☐ Asthma ☐ Bone or Joint Disease ☐ Broken Bones

☐ Bursitis ☐ Cancer ☐ Colon/Intestinal Disorders ☐ Diabetes

☐ Epilepsy ☐ Gout ☐ HIV ☐ Hemophilia

☐ Hepatitis ☐ Hypertension ☐ Tuberculosis ☐ Kidney Disease

☐ Stroke ☐ Tendinitis ☐ Venereal Disease ☐ Ulcers

☐ Heart Trouble Cardiologist Name: _________________________

☐ Other____

Please List Previous Surgeries and Hospitalizations for Past 5 Years:

Year ___________ Hosp ___________________________ Dr _____________________ Reason _________________________

Year ___________ Hosp ___________________________ Dr _____________________ Reason _________________________

Year ___________ Hosp ___________________________ Dr _____________________ Reason _________________________

Year ___________ Hosp ___________________________ Dr _____________________ Reason _________________________

Year ___________ Hosp ___________________________ Dr _____________________ Reason _________________________