

Medical History

Patient Name _____ DOB _____ Date _____

To help us meet your healthcare needs, please fill out both sides of this form completely. This is a confidential record of your medical history and will not be shared without your authorization.

Reason for Today's Visit: _____ Hand Dominance: ☐ R ☐ L

ALLERGIES

☐ No Known Allergies

Metal: ☐ No ☐ Yes, type _____ Adhesives: ☐ No ☐ Yes, type _____

Please list all other allergies (Drug and Food) you have been diagnosed with and reaction.

Allergic To:	Reaction:	Allergic To:	Reaction:
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATIONS

☐ No Current Medications

Please list all medications you are currently taking, prescribed and over the counter or provide a list.

Current Medication:	Dosage:	How often per day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST SURGICAL HISTORY

☐ No Past Surgical History

Please list all operations you have experienced and indicate year they occurred.

<input type="checkbox"/> Back Surgery _____	<input type="checkbox"/> Hand Surgery _____	<input type="checkbox"/> Knee Surgery _____
<input type="checkbox"/> Bowel/Stomach Surgery _____	<input type="checkbox"/> Heart Surgery _____	<input type="checkbox"/> Neck Surgery _____
<input type="checkbox"/> Cancer Surgery _____	<input type="checkbox"/> Hip Surgery _____	<input type="checkbox"/> Shoulder Surgery _____
<input type="checkbox"/> Fracture/Bones (Surgical) _____	<input type="checkbox"/> Joint Replacement _____	<input type="checkbox"/> Other _____

PAST MEDICAL HISTORY

☐ **No Past Medical History**

Please check any that apply.

- | | | |
|---|---|--|
| <input type="checkbox"/> Arthritis/Type _____ | <input type="checkbox"/> GERD (reflux) | <input type="checkbox"/> Lung Disease/Asthma |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> MRSA Infection |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Heart Condition/Disease | <input type="checkbox"/> Osteopenia/Osteoporosis |
| <input type="checkbox"/> Bone Fractures | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Pulmonary Embolism/DVT |
| <input type="checkbox"/> Cancer/Type _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Diabetes/Type _____ | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disease/Renal Insufficiency | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Other _____ | | |

FAMILY HEALTH HISTORY

Are you adopted? ☐ Yes ☐ No

Please indicate if any **Blood Relative** has had any of the following:

	Diabetes	High Blood Pressure	Heart Disease	High Cholesterol	Cancer (Type)	Mental Illness	Blood Disorder (Type)	Lung Disease	Kidney Disease
Father									
Mother									
Paternal Grandfather									
Paternal Grandmother									
Maternal Grandfather									
Maternal Grandmother									
Brother(s)									
Sister(s)									
Son(s)									
Daughter(s)									

SOCIAL HISTORY

- | | | | |
|---------------------------|------------------------------------|---|--|
| Do you use tobacco? | <input type="checkbox"/> Never | <input type="checkbox"/> Quit/Age _____ | <input type="checkbox"/> Yes—Type and amount per day? _____ |
| Do you use marijuana? | <input type="checkbox"/> Never | <input type="checkbox"/> Yes, Medical | <input type="checkbox"/> Yes, Recreational |
| Do you use vape products? | <input type="checkbox"/> Never | <input type="checkbox"/> Former | <input type="checkbox"/> Yes—How much? |
| Do you drink alcohol? | <input type="checkbox"/> Never | <input type="checkbox"/> Former | <input type="checkbox"/> Yes— How Much/Often? _____ |
| Do you use illegal drugs? | <input type="checkbox"/> Never | <input type="checkbox"/> Former | <input type="checkbox"/> Yes |
| Do you drink caffeine? | <input type="checkbox"/> Never | <input type="checkbox"/> Former | <input type="checkbox"/> Yes— How much? _____ |
| How much do you exercise? | <input type="checkbox"/> Sedentary | <input type="checkbox"/> 1-2x/month | <input type="checkbox"/> 1-2x/week <input type="checkbox"/> 3-4x/week <input type="checkbox"/> Daily |
| Marital Status: | <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Partner |

What is your current occupation? _____

- What is your education level?
- | | | |
|---|---|--|
| <input type="checkbox"/> Less than high school | <input type="checkbox"/> High school degree | <input type="checkbox"/> Some college |
| <input type="checkbox"/> Associate degree | <input type="checkbox"/> Bachelor's degree | <input type="checkbox"/> Master's degree |
| <input type="checkbox"/> Doctorate Degree or higher | | |