MEDICAL HISTORY WORKSHEET

Please briefly tell us about your current problem or injury: Please describe the reason we are seeing you today: _____

When did your first symptoms appear? (Provide the date if known) _____

Is this a Workers' Compensation Injury/Claim? No ❑ Yes ❑

Is this a result of a motor vehicle accident? No ❑ Yes ❑

What were you doing when the first symptoms appeared? _____

Would you describe your current pain as: mild ❑ moderate ❑ severe ❑ no pain ❑

How many hours a day are your symptoms present? 2-4 hrs❑ 4-8 hrs❑ 8-12 hrs❑ >12 hrs❑

What makes your symptoms worse? _____

What makes your symptoms better? _____

Please tell us about your health: Please circle any serious illnesses you have now or have had in the past:

ADD/ADHD	Coronary Artery Disease	Hypothyroidism
Anxiety/Depression	Prior MI/Heart Attack	MRSA Infection
Fibromyalgia	Hypertension	Tuberculosis
Gout/Pseudogout	Pacemaker/AICD	Kidney Disease
Lupus	MVP/Valve Disease	Kidney Failure/Dialysis
Osteoarthritis	Chronic Anemia/Blood Disorder	Latex Allergy
Psoriatic Arthritis	Chronic Leg or Foot Ulcers	Liver Disease/Hepatitis
Rheumatoid Arthritis	Chronic Migraines	Lymphedema
Mixed Connective Tissue Dz	Chronic Urinary Tract Infections/UTI's	Metal Sensitivity
Unspecified Arthritis	Diabetes - Diet Controlled	Osteoporosis/Osteopenia
Asthma/COPD/Emphysema	Diabetes - Non-Insulin Dependent	Seizure Disorder/Epilepsy
Bleeding Disorder	Diabetes – Insulin Dependent	Sleep Apnea
Blood Clots/DVT's	Ulcers/Bleeding Ulcers	Stroke and/or TIA's
History of Pulmonary Embolism	GERD/Reflux	Tetanus Vaccination
Cancer type:	Hernia	Peripheral Arterial Disease
Arrhythmia/Palpitations	High Cholesterol	Venous Insufficiency
CHF/Heart Failure	HIV / AIDS	
Anything Else?		

Please list all of your previous surg

Please list all of your previous surgeries and approximate year/decade performed:

I have never had surgery ❑

Surgery	When?
1.	
2.	
3.	
4.	

Surgery	When?
5.	
6.	
7.	
8.	

If you are currently taking medication on a regular basis, please list their names:

I am not currently taking any prescription medications ❑

1.	4.	7.
2.	5.	8.
3.	6.	9.

If you are allergic to any medications, please list the medication and its effect on you:

I have no allergies to medications ❑

Name	Effect
1.	
2.	
3.	
4.	

Name	Effect
5.	
6.	
7.	
8.	

Please tell us about yourself:

How tall are you? _____ How much do you weigh? _____

Which is your dominant (or writing) hand? Right ❑ Left ❑ Both ❑

How often do you drink alcoholic beverages?

None ❑ Occasional ❑ Moderate ❑ Heavy ❑

Do you use tobacco products? Yes ❑ No ❑

If Yes, Cigarettes ❑ Cigars ❑ Pipe ❑ Chew ❑ How much/day? _____ Individual ❑ Packs ❑

In what sports are you a regular participant? _____

Please tell us about your other health contacts:

Who is your primary care physician ? _____

Address:_____

Phone:_____

Which doctor referred you to us? _____

Address:_____

Phone:_____

Which is your primary local pharmacy? _____

Address:_____

Phone:_____

Which is your mail-order pharmacy? _____

Address:_____

Phone:_____

We will use this information to send updates to your Primary Care Provider and e-scribe your prescriptions as needed. Please remember to keep us updated if you have any changes to this information.