Medical History Form

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My Name	Date of Birth/My Age	Today's Date

Medications I am currently taking:

☐ I am currently taking no medications regularly

Medication	Dosage (mg)	How often	I take it for my:

Medical conditions that I have:

☐ No medical problems I know of

☐ High blood pressure	☐ Stomach ulcers/gastritis	☐ Thyroid problems	☐ Osteoarthritis
☐ High cholesterol	☐ Stomach reflux/GERD	☐ Kidney problems	☐ Rheumatoid arthritis
☐ Heart problems	☐ Irritable bowel syndrome	☐ Prostate problems/BPH	☐ Osteoporosis/brittle bones
☐ Heart attack	☐ Asthma	☐ Liver problems/hepatitis	☐ Stroke/CVA
☐ Diabetes	☐ Emphysema/COPD	☐ HIV/AIDS	☐ Neuropathy
☐ Blood clot formation/DVT	☐ Pulmonary embolus	☐ Cancer	☐ Depression
☐ Blood flow problems/PVD	☐ Pneumonia	☐ Sleep Apnea	☐ Alzheimer's
Other medical problems I have/more info:			

Allergies I have to medications:

☐ I have no known allergies to any medications

Medication	Type of reaction I had (rash, nausea, stopped breathing, etc.)

Operations I have undergone in the past:

☐ I have had no major operations in the past

☐ Appendectomy	☐ Heart surgery	☐ Shoulder surgery
☐ Tonsillectomy	☐ Cardiac catheterization	☐ Knee surgery
☐ Vasectomy	☐ Cardiac stent placement	☐ Previous bone or joint surgery:
☐ C-Section	☐ Colonoscopy/endoscopy	
Other Surgeries I have undergone/more info:		

Family Medical History:

☐ No medical problems in my family I know of

Medical problem:	In my (mother, father, etc.):	Medical problem:	In my:
☐ High blood pressure		☐ Osteoarthritis	
☐ High cholesterol		☐ Rheumatoid arthritis	
☐ Heart problems		☐ Other joint problems	
☐ Diabetes		☐ Osteoporosis/brittle bones	
☐ Asthma		☐ Neuropathy	
☐ Blood clot formation/DVT		☐ Alzheimer's	
☐ Bleeding problems		☐ Cancer	
☐ Anesthesia problems		☐ Other:	
☐ Stroke/CVA		☐ Other:	

I am active in:

☐ No specific sports or exercise	☐ Cycling	☐ Basketball	☐ Gymnastics
☐ Walking for fitness	☐ Mountain biking	☐ Golf	☐ Skiing
☐ Exercising at the gym	☐ Hiking	☐ Tennis	☐ Snowboarding
☐ Weight training	☐ Baseball/Softball	☐ Volleyball	☐ Dance/cheer
☐ Running	☐ Soccer	☐ Lacrosse	☐ Other:
☐ Swimming	☐ Football	☐ Hockey	

Alcohol Use:	Tobacco use:	Recreational drug use:
☐ None/ rarely	☐ I don't smoke	☐ None
☐ 1-2 drinks/week	☐ I quit in _________ after smoking	☐ Occasionally
☐ 1-2 drinks/day	_______packs/day for _______years	☐ Regularly
☐ Three or more drinks/day	☐ ½ to 1 pack/day	☐ Drugs I commonly use:
☐ Difficulty with heavy alcohol use in the past	☐ 2 or more packs/day	

Review of systems:

These are symptoms I commonly experience (check only if yes):

☐ Seasonal allergies/hayfever
☐ Dermatitis
☐ Frequent itching
☐ Skin reactions
☐ Reactions to Latex/rubber gloves
☐ Runny nose
Describe:

☐ Fever
☐ Fatigue
☐ Unexplained weight loss
☐ Weakness all over
Describe:

☐ Chest pain
☐ Heart palpitations
☐ Rapid heart beats
☐ Irregular heart beats
☐ High blood pressure
Describe:

☐ Changes in skin color
☐ Skin rashes
☐ Skin masses
☐ Skin sores/ulcers
☐ Skin cancers
Describe:

☐ Frequent thirst
☐ Frequent hunger
☐ Hyperactivity
☐ Hypoactivity
☐ Growth changes
☐ Hair changes
Describe:

☐ Decreased hearing
☐ Ringing in the ears
☐ Dizziness
☐ Hoarseness
☐ Sinusitis
Describe:

☐ Bleeding tendency
☐ Easy bruising
☐ Lymph node enlargement
☐ Anemia
Describe:

☐ Abdominal pain
☐ Nausea
☐ Stomach ulcers/reflux
☐ Heartburn/indigestion
☐ Appetite change
☐ Change in bowel habits
☐ Diarrhea
☐ Constipation
☐ Loss of appetite
Describe:

☐ Bone fractures
☐ Joint sprains
☐ Joint swelling
☐ Low back pain
☐ Joint stiffness
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Fibromyalgia
Describe:

☐ Headaches
☐ Speech difficulty
☐ Stroke/TIA
☐ Numbness, tingling
☐ Seizures/epilepsy
☐ Balance problems, falls
Describe:

☐ Double vision
☐ Blurry vision
☐ Eye trauma
☐ I wear glasses/contacts
Describe:

☐ Mood swings
☐ Sleep problems
☐ Depression
☐ Anxiety
☐ Substance abuse
☐ Heavy alcohol use/drinking
Describe:

☐ Shortness of breath
☐ Asthma
☐ Bronchitis
☐ Chronic lung problems
☐ Chronic cough
Describe:

☐ Difficulty passing urine
☐ Incontinence
☐ Frequent urination
☐ Urinary tract infections
☐ Painful menstruation/PMS
Describe:

Here's why I want to get this treated:

☐ relief from the pain	☐ get back to exercising, like:	☐ get back to sports, like:
☐ get back to normal day to day living		
☐ heavy work on the job		
Other:		