Past Medical History

Clear Form

Patient Name:_____ Date of Birth: _____

Current Concern

What specific problem brings you to our office today?_____

Where is the pain/problem located?_____

Allergies

Medications_____ Anesthesia_____ Foods_____

Tape☐ Latex☐ Shellfish☐ Iodine☐ Other☐_____ or None Known☐

Current Medications: Please list all medications that you are taking (Includes prescriptions, over-the-counter medications, and herbal supplements):

Name	Dose	How often do you take it?

Pharmacy: Name:_____ Cross Roads:_____

Phone #:_____

Medical History

Current/Past Medical History: Please circle the follow that apply to you.

☐	Acid Reflux	☐	Fibromyalgia	☐	Neuropathy
☐	Anemia	☐	Gout	☐	Open Sores
☐	Arthritis	☐	Heart Attack	☐	Pneumonia
☐	Asthma	☐	Heart Disease/Failure	☐	Polio
☐	Back Trouble	☐	Hepatitis	☐	Rheumatic Fever
☐	Bladder Infection(s)	☐	HIV+/AIDs	☐	Sickle Cell Disease
☐	Abnormal Bleeding	☐	High Blood Pressure	☐	Skin disorder
☐	Blood Clots	☐	Kidney Disease	☐	Sleep Apnea
☐	Blood Transfusion	☐	Liver Disease	☐	Stomach Ulcers
☐	Bronchitis/Emphysema	☐	Low Blood Pressure	☐	Stroke
☐	Cancer	☐	Migraine Headaches	☐	Thyroid Disease
☐	Diabetes: Type I ☐ Two II ☐	☐	High Cholesterol	☐	Tuberculosis

Other Conditions:_____

Past Medical History

Patient Name:_____ Date of Birth: _____

Surgical History

Type of Surgery & Date of Surgery

_____ _____

_____ _____

_____ _____

_____ _____

Social History

Marital Status:

☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Alcohol Use

☐ Never ☐ Yes ☐ No

☐ Alcohol Frequency: Rare☐ Occasionally☐ Moderate☐ Daily☐ Type:_____

Tobacco Use: Chewing Tobacco☐ Smoking Tobacco☐

☐ Never ☐ Quit- How long ago?____ ☐ Smoke____packs/day____years

Recreational Drugs

☐ Never ☐ Quit-How long ago?_____ Type_____ ☐ Current use- Type _____ Frequency: ☐Rare ☐Occasionally ☐Moderate ☐Daily

Occupation_____

How much are you on your feet at work? 10%☐ 25%☐ 50%☐ 75%☐ 100%☐

Exercise: Never☐ Rare☐ Occasionally☐ Weekly☐ Several Times a week☐ Daily☐

Family History (Put a YES mark by the issue that the specific member of your family member has experienced/had. Leave blank if they have not experienced it)

Relationship	Diabetes	Cancer	Heart disease	High Blood Pressure	Stroke	Coronary Heart Disease	Thyroid disease	Rheumatoid Arthritis	High Cholesterol
Mother									
Father									
Brother/Sister									
Maternal Grandfather									
Maternal Grandmother									
Paternal Grandfather									
Paternal Grandmother									

Other Conditions_____