

# Patient Medical History Form

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

PRIMARY CARE DOCTOR: \_\_\_\_\_

DOMINANT HAND: RIGHT or LEFT

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TOBACCO USE: YEAR STARTED \_\_\_\_\_ # OF PACKS PER DAY: \_\_\_\_\_ YEAR QUIT \_\_\_\_\_

ALCOHOL: AVERAGE AMOUNT OF ALCOHOL YOU DRINK PER DAY \_\_\_\_\_

HAVE YOU EVER USED STREET/RECREATIONAL DRUGS? YES OR NO

.....

CHIEF COMPLAINT: (Please briefly list all symptoms/ why your are here today)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU EVER HAD SIMILAR PROBLEMS IN THE PAST?

\_\_\_\_\_

HAVE YOU EVER HAD ANY OTHER SIGNIFICANT INJURIES, ACCIDENTS, FALLS, REASONS FOR DISABILITY OR PERIODS OFF WORK?

\_\_\_\_\_

## PAST MEDICAL HISTORY:

Complete Medication list/Why:  
(Including Aspirins/ Vitamins Ect)

List all operations/hospitalizations:  
(Include approximately the year done)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(ATTACH MEDICINE LIST IF NECESSARY)

HAVE YOU BEEN TESTED FOR:

ALLERGIES

HIV \_\_\_\_\_ HEPATITIS \_\_\_\_\_ OTHER \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

DO YOU HAVE PROBLEMS WITH:

Ears/Nose/Throat \_\_\_\_\_ Eyes \_\_\_\_\_ Heart \_\_\_\_\_ Lungs \_\_\_\_\_ Digestion \_\_\_\_\_ Urinary Tract \_\_\_\_\_  
Nervous System \_\_\_\_\_ Diabetes \_\_\_\_\_ Other \_\_\_\_\_

FOR WOMEN ONLY: ARE YOU NOW, OR COULD YOU BE, PREGNANT? Yes or No

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## OFFICE USE ONLY

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ BLOOD PRESSURE: \_\_\_\_\_ PULSE \_\_\_\_\_