

# 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

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

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HAVE YOU EVER HAD SIMILAR PROBLEMS IN THE PAST?

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

## PAST MEDICAL HISTORY:

**PLEASE USE THE BACK OF  
THIS PAGE FOR YOUR  
CURRENT MEDICATIONS**

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

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### ALLERGIES

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HAVE YOU BEEN TESTED FOR:

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

DO YOU HAVE PROBLEMS WITH:

Ears/Nose/Throat: yes \_\_ no \_\_ Eyes: yes \_\_ no \_\_ Heart: yes \_\_ no \_\_ Lungs: yes \_\_ no \_\_ Digestion: yes \_\_ no \_\_

Urinary Tract: yes \_\_ no \_\_ Nervous System: yes \_\_ no \_\_ Diabetes: yes \_\_ no \_\_ 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 \_\_\_\_\_

**Medication List**

Please list all medications you are currently taking. Please include over the counter medications and vitamins.

**Medication & Dosage**      **Directions**      **Reason**      **Prescribing Doctor**      **Start Date**

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