Medical History Form

Name: ______________________________ Today's Date: ______________

Age ______________ Height: __________ Weight: __________

State in your own words the nature of your problem. (Briefly) ______________________________

____

How long have you had this problem? ______________________ Onset Date: ______________

Is this problem related to an injury? ______ If yes, describe the injury briefly. (Is it work related) ______________

____

Is this problem related to a previous illness? ______ If yes , describe the illness briefly. ______________

____

Have you had treatment for this problem? ______ If yes, describe the treatment briefly. ______________

____

Employer: ______________________________

Describe your job briefly: ______________________________

____

List allergies: ______________________________

List current medications: Coumadin Yes No Heprin Yes No Other meds: ______________

____

List previous surgical procedures: ______________________________

Have you had previous bone, joint, or muscle disorder or injury? ______ If yes, describe briefly. ______________

____

Changes to your medical history conditions since your last admission:

Condition	Yes	No	Condition	Yes	No
Diabetes	Yes ☐	No ☐	Polio	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Jaundice	Yes ☐	No ☐
Rheumatic Fever	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Lung Disease, asthma	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Tuberculosis	Yes ☐	No ☐	Neurological Disorder	Yes ☐	No ☐
Kidney (Renal) Disease	Yes ☐	No ☐	Cancer Site ______	Yes ☐	No ☐

Is there a history of any of the above diseases in your family? ______ If so, which ones? ______________

____

Do you smoke? ______ How much? ______________________________

Do you drink alcoholic beverages? ______ If yes, how much daily/weekly. ______________

Female History: (for ultrasound purposes) Last monthly period ______________ Could you be pregnant? Yes No

Additional information you may feel significant: ______________________________

____

With Whom do you live? Alone ______ Spouse ______ Child ______ Other ______________

Do you use an assistive device? Cane ______ Walker ______ Wheelchair ______ Other ______________