

Medical History

Name: _____

Date: _____

Social Security Number: _____ Age: _____

Date of Birth: _____

Referring Doctor: _____

Phone No: _____

Location of Doctor: _____

Male or Female

Date of injury or onset: _____

Right handed or Left handed

Body Part to be examined by doctor (include **Rt** or **Lt** side) _____

Does injury involve a motor vehicle? Yes / No

Did this injury occur while working? Yes / No

Give brief description of symptoms, include how & when? _____

Were X-Rays taken? _____ If yes where? _____

Is this a SECOND OPINION Yes / No Have you seen other doctors for this problem _____

Medication	Dose	How Long?	Side Effects?

Allergies: _____

Review of Systems

Circle if you have or had any of the following (it is important for the doctor to know when prescribing medications):

Heart disease, Lung disease, Stomach problems, Ulcers, Urine infections, Diabetes, Arthritis

High Blood Pressure, Bleeding Tendencies Cortisone Medication

Describe all **circled** responses _____

List any surgeries _____

Social History

Work Status:

__ Working Full or Part __ Retired __ Temp Disabled __ Perm Disabled

__ Work in home __ Employed by _____ __ Student

Have you missed work due to this problem? _____

Marital Status: __ Single __ Married __ Divorced __ Separated __ Widowed

Smoking Currently No / Yes Packs per day _____ Quit Smoking _____ How long _____

Alcohol consumption __ Daily __ Weekly __ Monthly __ Yearly

Family History

Member	Alive/Deceased	Age	Health Status/ Cause of Death	Member	Alive/Deceased	Age	Health Status/ Cause of Death
Grandmother (m)	A	D		Mother	A	D	
Grandfather (m)	A	D		Sister/Brother	A	D	
Grandmother (d)	A	D		Sister/Brother	A	D	
Grandfather (d)	A	D		Sister/Brother	A	D	
Father	A	D		Sister/Brother	A	D	

To be completed by staff

Height _____ Weight _____ Pulse _____ Initials _____

Reviewed by: _____ Date: _____