



Patient Name: \_\_\_\_\_ Provider: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Chart # \_\_\_\_\_ Date: \_\_\_\_\_

### MEDICAL HISTORY FORM

Age: \_\_\_\_ Sex:  F  M Primary Care Doctor's Name: \_\_\_\_\_ Did they evaluate this problem?  Y  N  
Dominant Hand:  R  L Height: \_\_\_\_\_ Weight: \_\_\_\_\_ (ORA staff to fill out the following: P \_\_\_\_\_ R \_\_\_\_\_ Temp \_\_\_\_\_)  
Who requested that you be seen here?  Primary care provider  Emergency room or urgent care provider  yourself  other  
What problem are you being seen for today?  R  L \_\_\_\_\_

When did your problem start or what was the date of the injury? \_\_\_\_\_

Were you seen in the E.R. for this problem?  Y  N Which E.R.? \_\_\_\_\_ Date \_\_\_\_\_

What tests/treatments have you had for this problem?  X-Rays  MRI  CT scan  Bone scan  Ultrasound  
 Nerve Test (EMG/NCV)  Physical Therapy  Medications  Previous surgery for this problem  Other \_\_\_\_\_

Since my problem started, it is:  Getting better  Getting worse  Unchanged

Has your problem kept you from:  Working  Recreational activities  Activities of daily living like cleaning & dressing yourself

I experience:  Pain  Bruising  Numbness  Tingling  Weakness  Loss of control bowel/bladder  
 Locking  Catching  Instability  Swelling  Stiffness  Other \_\_\_\_\_

If you have pain: How would you describe the type of pain?  Sharp  Dull  Stabbing  Throbbing  Aching  Burning

On a scale of 0 - 10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

The pain is:  Constant  Intermittent (comes & goes)

Does the pain radiate/travel/move?  Y  N If yes, where \_\_\_\_\_

Does your pain wake you from sleep?  Y  N

What makes your symptoms worse?  Walking  Stairs  Exercising  Twisting  Kneeling  Direct pressure  
 Standing  Sitting  Lying flat  Bending  Lifting  Coughing / sneezing

What makes your symptoms better?  Rest or not moving  Sitting  Lying  Standing  Exercise / movement  Elevation  
 Ice  Heat  Compression or bracing  Injections  Pain pills  Other medications

If there was a specific injury, please describe what happened:

### REVIEW OF SYSTEMS

Have you recently had any of these symptoms? Please  check all that apply. If none of the below apply, then mark  NONE.

- Skin**  
 Frequent Rashes  
 Open Wounds  
 Itchy/Red

- ENT**  
 Hearing Loss  
 Hoarseness  
 Difficulty Swallowing

- Neuro**  
 Headaches  
 Numbness  
 Weakness  
 Frequent Falls

- Kidney/Bladder**  
 Painful Urination  
 Kidney Problems  
 Urinary Infections

- Cardio**  
 Chest Pain  
 Irregular Beat  
 Calf Pain  
 Swelling Feet/Ankle

- Eye**  
 Blurred Vision  
 Vision Loss  
 Double Vision

- Digestive**  
 Heartburn  
 Nausea/Vomiting  
 Blood in Stool

- Glands**  
 Excessive Thirst  
 Frequent Urination  
 Always Hot/cold  
 Lymphedema

- Bones/Joints**  
 Osteoporosis  
 Joint Problems  
 Broken Bones

- Psych**  
 Drug Abuse  
 Alcohol Abuse  
 Depression  
 Anxiety

- Lung**  
 Short of Breath  
 Wheezing  
 Chronic Cough

- Blood**  
 Easy Bruising  
 Easy Bleeding

- Const**  
 Recent Weight Loss  
 Frequent Fever  
 Loss of Appetite



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### PAST MEDICAL HISTORY

List any other doctors and their specialty that you see: \_\_\_\_\_

Do you have a history of any of the following: (Please  check all that apply)

**Bones/Joints**

- Broken
- Osteoporosis
- Arthritis

**Heart**

- Open Heart
- Stents
- Heart attack
- Pacemaker

**Circulation**

- Blood Clots
- High Blood Pressure
- Stroke
- Elevated Cholesterol

**Current Infection**

- Pneumonia
- Hepatitis  A  B  C
- HIV/Aids

**Lung**

- Asthma
- COPD
- Emphysema
- Sleep Apnea

**Glands**

- Diabetes Type I
- Diabetes Type II
- Thyroid

**Kidney**

- Infection
- Stones

**Neuro**

- Neuropathy
- Seizures

**Psych**

- Anxiety
- Depression

**Digestive**

- Heartburn
- Reflux
- Ulcers
- Dialysis

**Other**

- Liver Disease
- Cancer
- \_\_\_\_\_

List all past surgeries and what year that they occurred:  NONE  Appendectomy  Tonsil  Adenoids  C-section/s  Bypass  Gall bladder  Tubes in ear  Hernia repair  Oral surgery  Hysterectomy  Tubal ligation  Orthopedic surgery (please list below)  Others: \_\_\_\_\_

Current medications, the dose and frequency (list all prescription and over the counter medications / supplements):

NONE  Please see list on separate sheet (please date the sheet and write your name on the sheet)

Are you allergic to any medications?  Y  N If yes, please list below and list the reaction (hives/stopped breathing/rash/swelling):

Other Allergies:  Latex  Food  Seasonal  Other **Have you ever had a reaction to anesthesia?**  Y  N \_\_\_\_\_

### FAMILY HISTORY

Adopted and family medical history is not known  No significant medical history of any direct relatives

List any major medical problems (examples: diabetes, heart disease, cancer, arthritis ...) of your direct relatives:

Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Grandparents: \_\_\_\_\_

Brothers/Sisters: \_\_\_\_\_ Children: \_\_\_\_\_

### SOCIAL HISTORY

Do you use tobacco?  No  Quit  Yes - How much? \_\_\_\_\_ Alcohol use?  No  Yes - How much? \_\_\_\_\_

Are you currently working?  Y  N Type of job: \_\_\_\_\_  Disabled  Retired

Student at \_\_\_\_\_ What grade level \_\_\_\_\_ Participating in what sports? \_\_\_\_\_

Marital Status:  Single  Married  Widowed Children:  Y  N

Patient Signature The information on this form is accurate to the best of my knowledge.

Date

FOR OFFICE USE ONLY: (Initial and date when completed and with each update)

Review#1 by:

Date

Review #2 by:

Date