



Patient Name: _____ Provider: _____

Date of Birth: _____ Chart # _____ Date: _____

MEDICAL HISTORY FORM

Age: _____ Sex: F M Dominant Hand: R L Height: _____ Weight: _____ (ORA Only BMI _____)

What problem are you being seen for today? R L _____

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

Referred Here By: Self Family Friend Primary Care ER / Urgent Care Other Healthcare Provider

Name of person making referral: _____ Did they evaluate this problem? Y N

Your primary care physician: _____ Internist: _____ Cardiologist _____

Neurologist: _____ Pulmonologist (Lung): _____ Other Specialist: _____

PROBLEM OR INJURY

When did your problem begin (date): _____ Where did the injury occur? _____

Was there an injury? Y N Did this occur at work? Y N Related to a Motor Vehicle Accident? Y N

What tests have you had for this problem? X-Rays _____ MRI _____ CT Scan _____
Where & When *Where & When* *Where & When*
 Bone Scan _____ Nerve Test (EMG/NCV) _____ Other _____
Where & When *Where & When* *Where & When*

Prior treatments for this problem? Ice Heat NSAIDS/Ibuprofen Physical Therapy Injections Pain Pills
 Compression or Bracing Chiropractic Surgery Other Medications

I experience: Pain Numbness Weakness Locking / Catching Instability Swelling Stiffness

Scale of 0 – 10 how severe is your pain (circle) 0 1 2 3 4 5 6 7 8 9 10 Pain wake you from sleep? Y N
No Pain >>>>>>>>>>>>>>> Worst Pain

Has your problem kept you from: Working Recreational Activities Activities of Daily Living (Cleaning & Dressing Yourself)

What makes your symptoms worse? Walking Stairs Exercising Twisting Kneeling Direct Pressure
 Standing Sitting Lying Flat Bending Lifting Coughing / Sneezing

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

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PAST MEDICAL HISTORY

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

- | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Heart
<input type="checkbox"/> Heart Failure / CHF
<input type="checkbox"/> Heart Attack
When _____ (Year)
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> A-Fib
<input type="checkbox"/> Defibrillator | Bones/Joints
<input type="checkbox"/> Broken
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Psoriatic Arthritis
<input type="checkbox"/> Gout
<input type="checkbox"/> Lyme Disease
<input type="checkbox"/> Ehlers Danlos | Circulation
<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Pulmonary Embolism
<input type="checkbox"/> On Blood Thinner
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> On Blood Press Meds
<input type="checkbox"/> Stroke _____ (Year)
<input type="checkbox"/> Elevated Cholesterol | Kidney
<input type="checkbox"/> Infection _____ (Year)
<input type="checkbox"/> Stones
<input type="checkbox"/> Dialysis
<input type="checkbox"/> Kidney Disease | Glands
<input type="checkbox"/> Diabetes Type I
<input type="checkbox"/> Diabetes Type II
<input type="checkbox"/> On Insulin
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Last A1C _____ |
| Smoking / Alcohol
<input type="checkbox"/> Smoke _____ Packs/Day
<input type="checkbox"/> Vape / Chew Tobacco
<input type="checkbox"/> Quit Smoking or Tobacco
When _____ (Date)
<input type="checkbox"/> Alcohol _____ Drinks/Week
<input type="checkbox"/> Marijuana
<input type="checkbox"/> Recreational Drugs | Anesthesia Reaction
<input type="checkbox"/> Severe Reaction
Explain _____
<input type="checkbox"/> Difficult Intubation
<input type="checkbox"/> Malignant Hyperthermia
<input type="checkbox"/> Significant Nausea
<input type="checkbox"/> Severe Motion Sickness | Lung
<input type="checkbox"/> Asthma
<input type="checkbox"/> COPD
<input type="checkbox"/> On Home Oxygen
<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Use CPAP
<input type="checkbox"/> Cancer
_____ (Type) | Neuro
<input type="checkbox"/> Neuropathy
<input type="checkbox"/> Seizures
When _____ (Year) | Current/Past Infection
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Hepatitis <input type="checkbox"/> B <input type="checkbox"/> C
<input type="checkbox"/> HIV / AIDS
<input type="checkbox"/> MRSA
<input type="checkbox"/> VRE
<input type="checkbox"/> COVID-19
When _____
<input type="checkbox"/> Current Infection |
| | | | Digestive
<input type="checkbox"/> Reflux
<input type="checkbox"/> Ulcers | Psych
<input type="checkbox"/> Drug / Alcohol Abuse
<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety |

Check past surgeries that you have had: NONE

- Heart Surgery _____ (Year) Bypass Catheterization Stents # _____ and _____ (Year) Valve Replaced
 Other Surgery _____
 Knee Arthroscopy (R / L) Shoulder Arthroscopy / Rotator Cuff (R / L) Knee Replacement (R / L) Shoulder Replacement (R / L)
 Hip Replacement (R / L) ACL Surgery (R / L) Spine Surgery _____ Other Orthopedic Surgery _____

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, difficulty breathing, rash, swelling)

Medications Allergic to and Reaction: _____

Other Allergies: Latex Food _____ (Type) Other _____

FAMILY HISTORY

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

Check if you have Family History (Mother, Father, Grandparents, Siblings or Children) of these problems:

- Blood Clots Bleeding Disorders Heart Disease High Blood Pressure Stroke Kidney Disease Rheumatoid Arthritis
 Lung Disease Diabetes Seizures Liver Disease Malignant Hyperthermia Lupus Cancer _____ (Type)

SOCIAL HISTORY

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

Student at _____ What Grade _____ Participating in What Sports _____

Are you pregnant? Y N Unknown Started Menstrual Period (Females 8-15) Y N What Age _____

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

Form-#285