# MEDICAL HISTORY FORM

**Name:** ____________________

**MR#:** ____________________

**Date:** ____________________

Weight:________ Height:________ Age:________

**Past Medical History/Review of Systems**

Please check (X) the box next to any illnesses or problems that apply to you.

- ☐ Cancer
- ☐ Alcoholism
- ☐ Ulcers
- ☐ Cholesterol
- ☐ Asthma
- ☐ Heart Trouble
- ☐ Kidney Disease
- ☐ Sickle Cell Anemia
- ☐ Tuberculosis/HIV
- ☐ Emphysema/COPD
- ☐ High Blood Pressure
- ☐ Bleeding Disorder
- ☐ Liver Disorder
- ☐ Birth Defects
- ☐ Stroke
- ☐ Arthritis
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Gout

Please Explain: ____________________

☐ Other: ____________________

**Skeletal Health:**

- ☐ History of falls/fractures?
- ☐ Steroid Use?
- ☐ Do you smoke or drink?
- ☐ Vitamin deficiency?
- ☐ Do you exercise infrequently?
- ☐ Do you have a thin or petite build?
- ☐ Have you ever had a Bone Density Test?

**Surgery / Fractures**

Please check (X) the box next to any surgical procedures which you have had.

- ☐ Tonsils
- ☐ Ovaries
- ☐ Thyroid
- ☐ Joint Replacement
- ☐ Breast
- ☐ Stomach
- ☐ Kidney
- ☐ Appendix
- ☐ Prostate
- ☐ Hernia (repair)
- ☐ Arthroscopy
- ☐ Uterus
- ☐ Small Intestine
- ☐ Heart
- ☐ Gall Bladder
- ☐ Colon
- ☐ Pacemaker
- ☐ Extremities, Neck, Back (What kind):____________________
- ☐ Any other surgeries (What kind):____________________

**Allergies** **Please check allergies that apply to you.(X) the box next to any**

**If you do not have allergies please check (X) none.**

☐ Penicillin ☐ Sulfa ☐ Metal ☐ None

Other Antibiotics or other Drugs/medications

What kind: ____________________

Any foods/cosmetics or other allergies

What kind: ____________________

**Medications** (blood thinners, non-prescription remedies?)

Name of drug and how often it is taken:

____________________

____________________

____________________

____________________

____________________

____________________

____________________

**Do you have any of the following Conditions?**

- ☐ Shortness of breath
- ☐ Unexpected Weight Loss
- ☐ Constipation / Diarrhea / Blood in stools
- ☐ Chest Pain
- ☐ Fever / Chills
- ☐ Blurred Vision
- ☐ Headaches
- ☐ Frequent / Painful Urination
- ☐ Numbness in Extremities

**Tobacco Use**

Cigarettes: Yes / No Packs/day __________ Years of use ______

Other tobacco use: ____________________

**Alcohol Use:**

☐ Beer/Wine: __________ x a week

☐ Shots/Liquor: __________ x a week

☐ Other drug use: ____________________

**Family History**

Please check (X) the box next to any disease diagnosed in your blood relatives.

- ☐ Cancer
- ☐ Gout
- ☐ Diabetes
- ☐ Bleeding Problems
- ☐ Rheumatoid Arthritis
- ☐ Sickle Cell Anemia
- ☐ Other type of arthritis
- ☐ Heart Disease
- ☐ Other: ____________________

**Social History**

Are you? ○ Single ○ Married ○ Divorced ○ Widowed

Work Status: ○ Unemployed ○ Disabled ○ Retired ○ Student

Employed – Doing what? ____________________

Who lives in your house that can care for you or for whom you have to care? ____________________

**WHO IS YOUR PRIMARY CARE PHYSICIAN ?** ____________________

**PHYSICIAN NUMBER** ____________________

**Sign Here:** ____________________

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