**Past Medical History**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_**Date**:\_\_\_\_\_\_\_\_\_

**Reason for Visit**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PCP:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **No Medical Diagnosis**

**Check the condition(s) that apply to your past medical history -**

* Anemia
* Anesthesia problem
* Anxiety
* Arthritis
* Asthma
* Atrial Fibrillation
* Back Problems
* Bladder Infections
* Bleeding Disorder
* Blood Clots / CVT
* Blood Transfusions
* Bronchitis
* Cancer
* Cataracts
* Chicken Pox
* Congestive Heart Failure
* COPD / Emphysema
* Crohns / Ulcerative Colitis
* Dementia
* Depression
* Diabetes
* Diverticulitis
* Eczema
* Epilepsy / Seizures
* Fibromyalgia
* Glaucoma
* Gout
* Heart Attack
* Heart Burn
* Heart Disease / CAD
* Heart Murmur
* Hemorrhoids
* Hepatitis
* High Blood Pressure
* High Cholesterol
* HIV/ AIDS
* Hyperthyroid / Hypothyroid
* Insomnia
* Irritable Bowel Syndrome
* Kidney Disease
* Kidney Stones
* Liver Disease/ Cirrhosis
* Lung Disorder
* Lupus
* Malaria
* Measles
* Migraine Headaches
* Mitral Valve Prolapse
* Mumps
* Neuropathy
* Osteoporosis
* Pacemaker
* Pancreatitis
* Parkinson's
* Peripheral Vascular Disease
* Pneumonia
* Polio
* Pulmonary Embolism
* Rheumatic Fever
* Rheumatoid Arthritis
* Seasonally Allergies
* Sexually Transmitted Diseases
* Shingles
* Sleep Apnea
* Smallpox
* Stroke / TIA
* Tuberculosis
* Urinary Incontinence
* Vertigo
* Whooping Cough

**Smoking Status:**

* Current smoker If yes, Packs/day:\_\_\_\_ Number of Years:\_\_\_\_
* Former smoker Quit Date: \_\_\_/\_\_\_/\_\_\_\_\_
* Never smoker

**Alcohol Use Status:**

* Does not drink
* Currently drinks If yes, Alcohol Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drinks/Week:\_\_\_\_\_\_\_\_\_\_
* Former drinker Quit: \_\_\_/\_\_\_/\_\_\_\_\_
* Quit

**Illicit/Illegal drugs Status:**

* Does not take drugs
* Currently takes drugs If yes, Drug Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Former drug user
* Quit Quit: \_\_\_/\_\_\_/\_\_\_\_\_

**Injury Information/ Type of Injury: Related to current symptoms**

* Work If yes, Injury Date: \_\_\_/\_\_\_/\_\_\_\_\_ Injury Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Auto
* Sports
* Other

**Family Medical History  
Check the condition(s) that apply and indicate which family member:**

**Condition: Relationship to patient: eg. Mother, Father, Sister, son**

* Anemia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Arthritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­
* Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Blood Clots/DVT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* COPD/Lung Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Depression \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Heart Disease/CAD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Hepatitis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* HIV/AIDS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* High Cholesterol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Irregular Heartbeat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Liver Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Osteoporosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Prostate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Stomach Ulcer/Reflux \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Stroke/Seizures \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Vascular Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Thyroid Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgeries**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surgery/Procedure** | **Hospital** | **Date** | **Comments** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Current Prescriptions and Over-the-counter Medications**

|  |  |  |  |
| --- | --- | --- | --- |
| **Drug name** | **Dosage** | **Drug name** | **Dosage** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Do you take aspirin or anti-inflammatory medications? No Yes- Please list below**

What is your preferred pharmacy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you take any of the following medications? Plavix Coumadin Warfarin Pradaxa Xeralto**

**Patient Drug Allergies**

* **No known drug Allergies.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Allergy** | **Severity (Mild, Moderate, Severe)** | **Date** | **Comments** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |