

# MEDICAL HISTORY

Acct.: \_\_\_\_\_

Dr. #: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Hand Dominance: Right Hand  Left Hand

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employed how long? \_\_\_\_\_

Are you disabled?  Yes  No If yes, when were you disabled? \_\_\_\_\_

1) Date your problem began: \_\_\_\_/\_\_\_\_/\_\_\_\_  Accident / Injury  Ongoing, no accident / injury  Sudden onset, no accident / injury

2) List the body part(s) you are being seen for today: \_\_\_\_\_

3) Describe how your accident / injury happened, or how the pain started: \_\_\_\_\_

4) Physicians who have treated you for this problem, and treatment received: \_\_\_\_\_

5) Diagnostic tests for this problem, check all that apply:  MRI  CT Scan  X-rays  
 Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_

Other studies done, please indicate: \_\_\_\_\_ Date: \_\_\_\_\_

6) Previous surgeries?  Yes  No If yes, please list: \_\_\_\_\_

7) Do you have any of the following medical problems? Check all that apply:  None

<input type="checkbox"/> Joints	<input type="checkbox"/> Lungs	<input type="checkbox"/> Stomach	<input type="checkbox"/> Heart	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Colitis	<input type="checkbox"/> Blockage of Vessels	<input type="checkbox"/> History of Shingles
<input type="checkbox"/> Degenerative Joints	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Clotting Disorder	<input type="checkbox"/> Carpel Tunnel Syndrome	<input type="checkbox"/> Trigger Digits
<input type="checkbox"/> Reflex Sympathetic Dystrophy	<input type="checkbox"/> Hepatitis			
<input type="checkbox"/> Weight Problems	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Urinary / Kidney Problems	<input type="checkbox"/> Psychiatric Problems	
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Sexual Dysfunctions	<input type="checkbox"/> Sleep Apnea	
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> HIV / AIDS			

8) Have you had a chronic cough for more than 3 weeks?  Yes  No  
 If yes, is it productive?  Yes  No Bloody?  Yes  No

9) Have you been experiencing night sweats?  Yes  No

10) Have you recently traveled outside the United States to another country where TB (Tuberculosis) is prevalent or are you currently living with another person who is currently being treated for active TB?  Yes  No

11) List all medications, vitamins, health food supplements, homeopathic medications or herbal remedies taken over the past six months: \_\_\_\_\_

This section is to be completed by office staff

BP: \_\_\_\_\_ Pulse \_\_\_\_\_ Weight \_\_\_\_\_  
 Temp: \_\_\_\_\_ Respiration: \_\_\_\_\_

12) Are you: Claustrophobic?  Yes  No Using a Pacemaker?  Yes  No Pregnant?  Yes  No  Maybe

13) Do you have allergies?  Yes  No If yes, please check all that apply:

Metals Type: \_\_\_\_\_  
 Medication Type: \_\_\_\_\_  
 Other Type: \_\_\_\_\_

14) Does anyone in your family have a serious health problem?  Yes  No If yes, please explain: \_\_\_\_\_

15) Do you: Smoke?  Yes  No If yes, please indicate number of packs per day \_\_\_\_\_ and number of years \_\_\_\_\_  
 Drink?  Yes  No If yes, please indicate number of drinks per day \_\_\_\_\_

Use over the counter (non prescription) medication?  Yes  No If yes, indicate what \_\_\_\_\_

16) Do you have ANY type of  Metal Implants  Screws  Rods  Plates  Shrapnel  Bullet Fragments  Breast Implants?

Indicate what part of the body is involved: \_\_\_\_\_

Patient / Guarantor Signature \_\_\_\_\_