PATIENT NAME: _____ DATE: _____

ADULT PATIENT MEDICAL HISTORY

The completion of this form is important to ensure the quality and accuracy of your care. This information is personal and confidential.

IS THIS A WORK-RELATED INCIDENT: YES / NO IF YES, DO YOU HAVE OR PLAN TO HAVE A WORK COMP CLAIM; YES / NO

IS THIS RELATED TO A MOTOR VEHICLE ACCIDENT: YES / N0 IF YES, DATE OF ACCIDENT: _____

***CHIEF COMPLAINT*:** _____

DURATION: _____ DATE INITIAL DIAGNOSIS GIVEN: _____

Preferred Pharmacy: (address/phone number) _____

Current Medications: Please list name, dose, times per day and prescribing physician. Also include all over the counter/supplemental medications.

Allergies: Please be sure to list any life-threatening allergies including XRAY dye, Shellfish, Iodine, Adhesive tape, antibiotics or metals and what type of reaction occurs.

Past Medical History: Examples would be asthma, high blood pressure, cancer, high cholesterol, thyroid, diabetes, hepatitis, osteoporosis, blood clots, HIV/AIDS ect. Please include any hospitalizations.

Anesthesia Complications: Have you had any complications or reactions with anesthesia or anything associated with surgery? If yes, please explain:

Patient Name: _____ Date: _____

Surgical History:

Year	Procedure	Surgeon	Hospital/Location

Family History: (blood related) Please List which family member- **Mother, Father, Maternal/Paternal Grandparents or siblings** on any **YES** history.

YES / NO Anesthesia Problems _____
YES / NO Heart Attack _____
YES / NO Bleeding Problems _____
YES / NO Heart Disease _____
YES / NO Cancer _____
YES / NO Hypertension (high blood pressure)_____
YES / NO Diabetes _____
YES / NO Blood Clots _____
YES / NO Heart Attack-Male under 55 _____
YES / NO Tuberculosis _____
YES / NO Heart Attack-Female under 65 _____
YES / NO Scoliosis _____
YES / NO Osteoporosis _____
YES / NO Stroke _____
YES / NO Rheumatoid Arthritis _____

Social History:

Tobacco Use Currently? Yes / No How many years? _____ Packs/day? _____

Type: Cigarettes Pipe Cigar Electronic/Vape

Former tobacco use? Yes / No Year Quit? _____

Do you drink alcohol? Yes / No How often? Daily / Weekly / Monthly / Rarely

How much? 1-2 / 3-4 / 5-6 or more?

Marital History: Married / Single / Divorced / Widowed

Are you retired? Yes / No Currently on disability? Yes / No

Occupation: _____

Patient Name: _____ Date: _____

Review of Personal History/ Systems: Circle all that apply

Fever/Chills	Pain on Urination	Thirsty All the Time
Wheezing	History of Seizures	Lung/Pulmonary Issues
Itching	Ears Ringing	Joint Swelling
Fatigue	Incontinence	Easy Bruising
Heartburn	Anxiety	Stress Test
Numbness	Trouble Swallowing	Arthritis
Sleep Problems	Increased Frequency	Bleeding
Constipation	Depression	Heart Catheterization
Tingling	Chest Pain	Cramps Frequent
Blurry Vision	Leg Pain	Infections
Nausea	Excessive Worry	Shortness of Breath
Headaches	Fainting	Weakness
Double Vision	Arm Pain	Enlarged Lymph Nodes
Vomiting	Memory Loss	Cough
Stroke	Hypertension	Rash
Decreased Hearing	Neck Pain	Hepatitis
Diarrhea	Weight Change	Asthma

MY PAIN IS: Please circle all that apply

Aching	Tender	Numb	Miserable	Unbearable
Sharp	Nagging	Stabbing	Gnawing	Electric
Penetrating	Shooting	Constant	Tiring	
Throbbing	Burning	Exhausting		

***MY PAIN IS WORSE WITH*:**

Walking Standing Sitting Bending Working Physical Activity

My Pain is made better by: _____

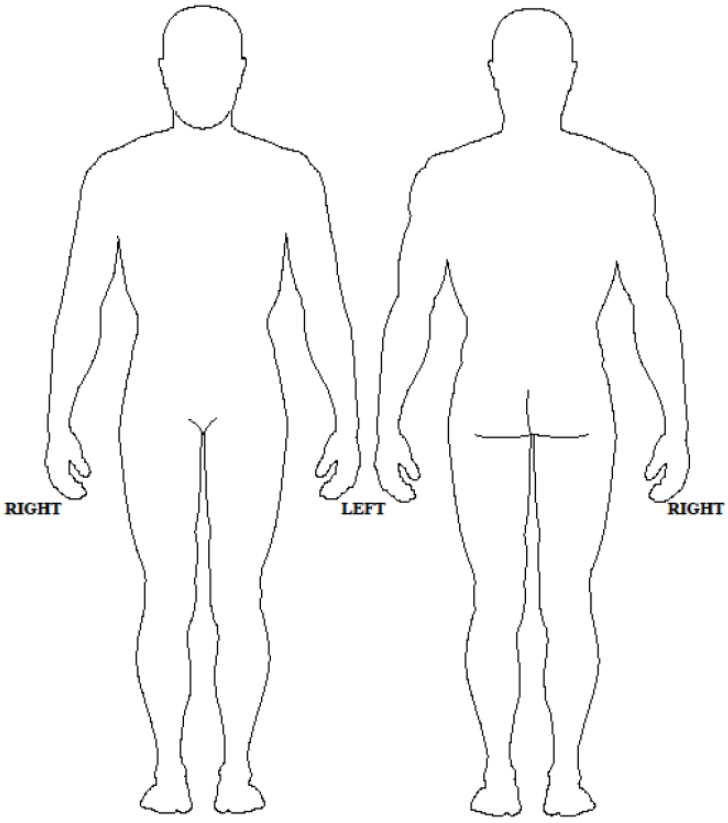
Please circle the number that best describes your pain level today (0 being none and 10 being extreme)

0 1 2 3 4 5 6 7 8 9 10

Patient Name: _____ Date: _____

PAIN DRAWING

Please mark below on the pain drawing where/ if you experience pain (XXX), tingling (000) or numbness (III)



ADDITIONAL COMMENTS: Please include any important information that was not covered in the above section that you feel will be important or pertinent to your care:

_____

_____

My signature below confirms that all information given is true and correct to the best of my knowledge.

_____ _____

Signature of Person Completing Form Date

_____ _____

Name of Person Completing Form Relation to Patient