

## Medical History Form

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Complaint: \_\_\_\_\_

Date of injury: \_\_\_\_\_

Have you been treated for this problem prior to coming to the office? **YES / NO**  
Where? \_\_\_\_\_ When? \_\_\_\_\_

Is your injury or complaint work related? **YES / NO**

Are you currently on disability? **YES / NO**

Are you currently working? **YES / NO**

Describe the work you currently do \_\_\_\_\_

Social History: **MARRIED / SINGLE / WIDOW**

Do you use alcohol? **YES / NO** Do you smoke? **YES / NO** Use Drugs? **YES / NO**

Past Medical History: What previous medical problems have you been treated for?

- |   |   |
|---|---|
| <input type="checkbox"/> Alcoholism                 | <input type="checkbox"/> Liver Disease                  |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Lung Disease                   |
| <input type="checkbox"/> Drug addiction             | <input type="checkbox"/> Non-Insulin Dependent Diabetes |
| <input type="checkbox"/> Heart Disease              | <input type="checkbox"/> Osteoarthritis                 |
| <input type="checkbox"/> Hypertension               | <input type="checkbox"/> Rheumatoid Arthritis           |
| <input type="checkbox"/> Insulin Dependent Diabetes | <input type="checkbox"/> Seizures                       |
| <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> Thyroid Disease                |

Cancer: **YES / NO** If so what type: \_\_\_\_\_

Past surgical history: What previous surgeries have you had? When? \_\_\_\_\_

What previous Orthopaedic surgeries have you had? When? \_\_\_\_\_

Did you have any complications with the surgery or anesthesia? **YES / NO**

Do you have any bleeding disorders? **YES / NO** Do you take any blood thinners? **YES / NO**

Do you currently have complaints with any of the following?

- |   |   |
|---|---|
| <input type="checkbox"/> Bowel Complaints     | <input type="checkbox"/> High Blood Pressure      |
| <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Muscle weakness          |
| <input type="checkbox"/> Chills               | <input type="checkbox"/> Shortness of Breath      |
| <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Skin Lesions             |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Throat complaints        |
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Ulcers                   |
| <input type="checkbox"/> Eyes Ears Nose       | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> Fevers               | <input type="checkbox"/> Weight Gain              |
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Weight Loss              |

Do you have any other medical conditions or problems that have not been discussed?  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient

OR

\_\_\_\_\_  
Parent / Legal Guardian / Authorized Person

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