



# Patient Medical History

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

Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Shoe size: \_\_\_\_\_

How did you hear about our office?

Website  Social Media  Referral from Physician  Friend/Family Member  Insurance

Online Provider Directory  Brochure/Print Ad Other: \_\_\_\_\_

## Chief Complaint: Circle your area of pain below.



In your own words, tell us what's wrong:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Pain Level:** (no pain 0 -10 severe pain)      0    1    2    3    4    5    6    7    8    9    10

## Surgical History:

**Procedure:** \_\_\_\_\_ **Date of Surgery:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Medical History: Check any past or current diagnoses.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Anxiety                          | <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Arrhythmia (irregular heartbeat) | <input type="checkbox"/> Heart failure (CHF) | <input type="checkbox"/> Pneumonia                   |
| <input type="checkbox"/> Asthma                           | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pulmonary embolism          |
| <input type="checkbox"/> Bleeding problems                | <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Reflux                      |
| <input type="checkbox"/> Blood clots (DVT/PE)             | <input type="checkbox"/> Infection           | <input type="checkbox"/> Rheumatoid arthritis        |
| <input type="checkbox"/> Cancer                           | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> Seizures                    |
| <input type="checkbox"/> Coronary artery disease          | <input type="checkbox"/> Open wounds/ulcers  | <input type="checkbox"/> Stomach ulcers              |
| <input type="checkbox"/> Depression                       | <input type="checkbox"/> Osteoarthritis      | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Osteoporosis        | Other: _____   |

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

### Current Medications:

Name of Medication:	Strength:	Frequency:

### Allergies:

Allergy:	Reaction:

Are you allergic to latex?  Yes  No  
Are you allergic to metals/jewelry?  Yes  No

Are you allergic to iodine?  Yes  No

### Social History:

**Do you use tobacco?**  Yes  No  
If yes: \_\_\_\_\_ packs per day, for \_\_\_\_\_ months \_\_\_\_\_ years

**Ex-smoker:**  Yes  No  
If yes: For how many years \_\_\_\_\_, when did you quit \_\_\_\_\_?

**Do you consume alcohol?**  Yes  No  
If yes: \_\_\_\_\_ drinks per day, for \_\_\_\_\_ months \_\_\_\_\_ years

**Do you use recreational drugs?**  Yes  No

List any sports or activities you enjoy: \_\_\_\_\_

Occupation: \_\_\_\_\_

### Family History:

Family Member:	Health Condition:	Alive/Deceased
Mother		
Father		
Maternal Grandparents		
Paternal Grandparents		