Name:
Chart:
Date:

PAST MEDICAL HISTORY

Name _____ Date _____
Date of Birth _____ Date of injury _____

1. Do you have or have you ever had any of the following? If so, please check.

HEART AND VASCULAR
__Heart attack
__Angina or chest pain
__High blood pressure
__Palpitation/heart skipping
__Heart murmur
__Stroke
__Edema - ankle swelling
__Varicose veins
__Phlebitis or blood clots
__Other heart-circulation problems
__Sleep apnea

LUNGS
__Bronchitis
__Emphysema
__Asthma
__Tuberculosis
__Sinusitis
__Hay-fever
__Respiratory infections
__Shortness of breath
__Black lung
__Other lung problems
_____

OTHER SYSTEMS
__Diabetes - Insulin/Non
__Thyroid problems
__Kidney/bladder problems
__Stomach or duodenal ulcer
__Heartburn or burping
__Convulsions - epilepsy
__Dizzy or fainting spells
__Hepatitis/jaundice/liver
__Pregnant Y / N
__HIV/AIDS
__Depression / Anxiety
__Arthritis/rheumatism
__Glaucoma
__Bleeding problems/anemia
__Psychiatric problems
__Back problems
__Alcoholism
__Drug Addiction
__Cancer - type _____
__Bone disorders
__Fibromyalgia
__Other _____

2. Please list prior surgeries and dates _____
_____

3. Are you taking any medications on a daily basis? Please list below or attach a separate listing.
Drug Name Strength Dosage
_____
_____
_____

4. Do you have any allergies to medications? If so, please list medication and reaction
_____

5. List any unusual childhood illnesses (scarlet or rheumatic fever, etc.)
_____

6. Do any medical problems run in your family? _____ DVT/Blood Clots _____ Other
_____ Hypertension _____ Diabetes _____ Heart Disease _____ Rheumatic arthritis. _____ Cancer

7. Do you smoke cigarettes, cigars or a pipe?
If so, how many per day? _____, for how many years? _____

8. Do you drink alcohol? Yes No If yes, how much per week _____

9. Tattoo within the past 6 months? _____

10. Do you live in a _____ one story home, _____ two story home or other? _____

11. Who lives at home with you? _____

12. Do you typically use a walker/cane/wheelchair? _____

13. What is your occupation? _____

14. Are you able to operate a vehicle? _____

15. Who is your primary care physician? _____

(for office use) Height _____ Weight _____ B/P _____ Age _____ BMI _____

The above information is true and complete to the best of my knowledge.

Patient Signature _____ Date _____

Physician/PA Signature _____ Date _____