Date: _________

BACKGROUND AND MEDICAL HISTORY

Name (Last, First) ______________________________ MI__________

Date of Birth: __________________ Age: ______ Sex: Female or Male Height_______ Weight ______

COMPLAINT:____

____

Medical Problems	Personal (Past & Present)	Family
High Blood Pressure		
Heart Attack		
Other Heart Disease		
Stroke		
Mental Illness		
Depression		
Diabetes		
Cancer		
Alcohol/Drug Use		
Kidney Problems		
Lung Problems		
Cataract		
Asthma		
Allergies		
Liver/Gallbladder		
Ulcer/Stomach		
Neurological Problem (Seizures/Parkinson's)		

Fracture (Spine/Hip/Leg)		
Thyroid/Endocrine		
Prostate (Men)		
Ovaries (Women)		

BACKGROUND AND MEDICAL HISTORY (CONTINUED)

SURGERY/PROCEDURE: (Include dates) ____

____

INJURIES/ACCIDENTS: ____

____

HOSPITILIZATION:____

____

MEDICATIONS:

Name of Medication	Dose	How many times a day
1. ________________________	_______	__________________________
2. ________________________	_______	__________________________
3. ________________________	_______	__________________________
4. ________________________	_______	__________________________
5. ________________________	_______	__________________________
6. ________________________	_______	__________________________
7. ________________________	_______	__________________________

Allergies:

____

____

Previous medical treatments/interventions in the past:

____

____

SOCIAL HISTORY

Marital Status	With Whom do you live?	Ethnic Background
☐ Never married	☐ With spouse	☐ White
☐ Alone	☐ With children	☐ Black
☐ Married	☐ With relative/friend	☐ Asian
☐ Divorced	☐ Retirement Home	☐ Hispanic
☐ Separated		☐ American Indian
☐ Widow/Widower		☐ Other

OCCUPATION: (If none, what you did in the past) Describe your work.

____

____

____

Are you currently working?	YES	NO	Date last worked?____________________
Alcohol Use	YES	NO	How much?___________________________
Tobacco Use	YES	NO	How much?___________________________

Disability Status/Legal Claims Pending: ____

____

Diagonstic Tests: (bloodwork, X-Rays/MRIs/CT Scan) ____

____

Please list any additional medications here: