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Medical History Information

Date: ______________________

NAME OF PATIENT: ____AGE: ______________

REFERRING DOCTOR/PA/NP/PT:____________________FAMILY DOCTOR:____________________

OCCUPATION:____Hand Dominance: ☐ R ☐ L

PRESENT HISTORY:

What is your chief complaint for this visit? ______________________________________

Date of accident or onset of symptoms: ______________________ Are you currently working? ________

What medications have you used for this problem? ______________________________________

Have you seen a physical therapist for this condition? Yes No Name: ______________________

Have you seen another doctor? Yes No Name: ______________________________________

What tests/treatments have you had? X-rays CT scan MRI Bone Scan Injections

PAST MEDICAL HISTORY **("I have had or have the following problem(s)")**

(Please circle any and all that apply)

Diabetes	Gout	Bleeding Disorders	Thyroid	Heart Disease	Phlebitis
Ulcers	Asthma	High Blood Pressure	Hepatitis	Kidney Problems	HIV
Arthritis	Seizures	Sickle Cell Disease	Stroke	Osteoporosis	
Lung Disease	Tuberculosis	Mental Illness	Rheumatoid Arthritis		

Cancer (List Type): ____

Other: ____

LIST ALL ALLERGIES TO MEDICINES AND FOODS AND REACTION: (If none write NKDA)

____

____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

(Include all over the counter drugs and alternative/herbal preparations)

Medication	Dosage	Medication	Dosage

LIST ANY PRIOR SURGERY (Include Dates): ______________________________

____

____

____

Physician Initials Date **Physician Initials Date** **Physician Initials Date**

HEIGHT ______**feet** ____**inches** **WEIGHT**_______**lbs.**

HANDEDNESS **Right** **Left**

FAMILY MEDICAL PROBLEMS:
Please circle any and all that apply

Diabetes	Gout	Bleeding Disorders	Thyroid	Heart Disease	Phlebitis
Ulcers	Asthma	High Blood Pressure	Hepatitis	Kidney Problems	HIV
Arthritis	Seizures	Sickle Cell Disease	Stroke	Osteoporosis	

Lung Disease Tuberculosis Mental Illness Rheumatoid Arthritis

Cancer (List type):

SOCIAL HISTORY:

Do you smoke? Yes No Number of packs per day: ________

Did you smoke in the past? Yes No Do you use illicit drugs? Yes No

When did you quit?__________________

Do you drink alcohol? Yes No Daily Weekly Monthly

REVIEW OF SYSTEMS: ("I have these symptoms related to my problem")
(Circle all that apply)

Fevers	Chills	Sweat	Weight Loss
Weight Gain	Rash	Hives	Itching
Bruising	Blurred Vision	Double Vision	Vision Loss
Glasses	Hearing Loss	Ringing in ears	Nose Bleeds
Sore Throat	Short of Breath	Wheezing	Swallowing Problems
Cough	Chest Pain	Palpitations	Use 2 or 3 pillows at night
Leg Swelling	Nausea	Vomiting	Diarrhea
Constipation	Abdominal Pain	Dark Stools	Bloody Stools
Painful Urination	Bloody Urine	Discharge	Lack of control of urination
Impotence	Vaginal Bleeding	Venereal Disease	Enlarged Thyroid
Goiter	Cold Intolerant	Heat Intolerant	Headaches
Fainting	Paralyses	Dizzy	Balance Problems
Memory Loss	Numbness	Weakness	Tremor
Depression	Anxious	Suicide Attempt	Sleeping Difficulties
Back Pain	Neck Pain	Joint Pain	Joint Swelling
Muscle Cramps	Stiffness	Other:	

PATIENT SIGNATURE: ________________________________ **DATE:** ________________

__________________ Physician Initials Date __________________ Physician Initials Date __________________ Physician Initials Date

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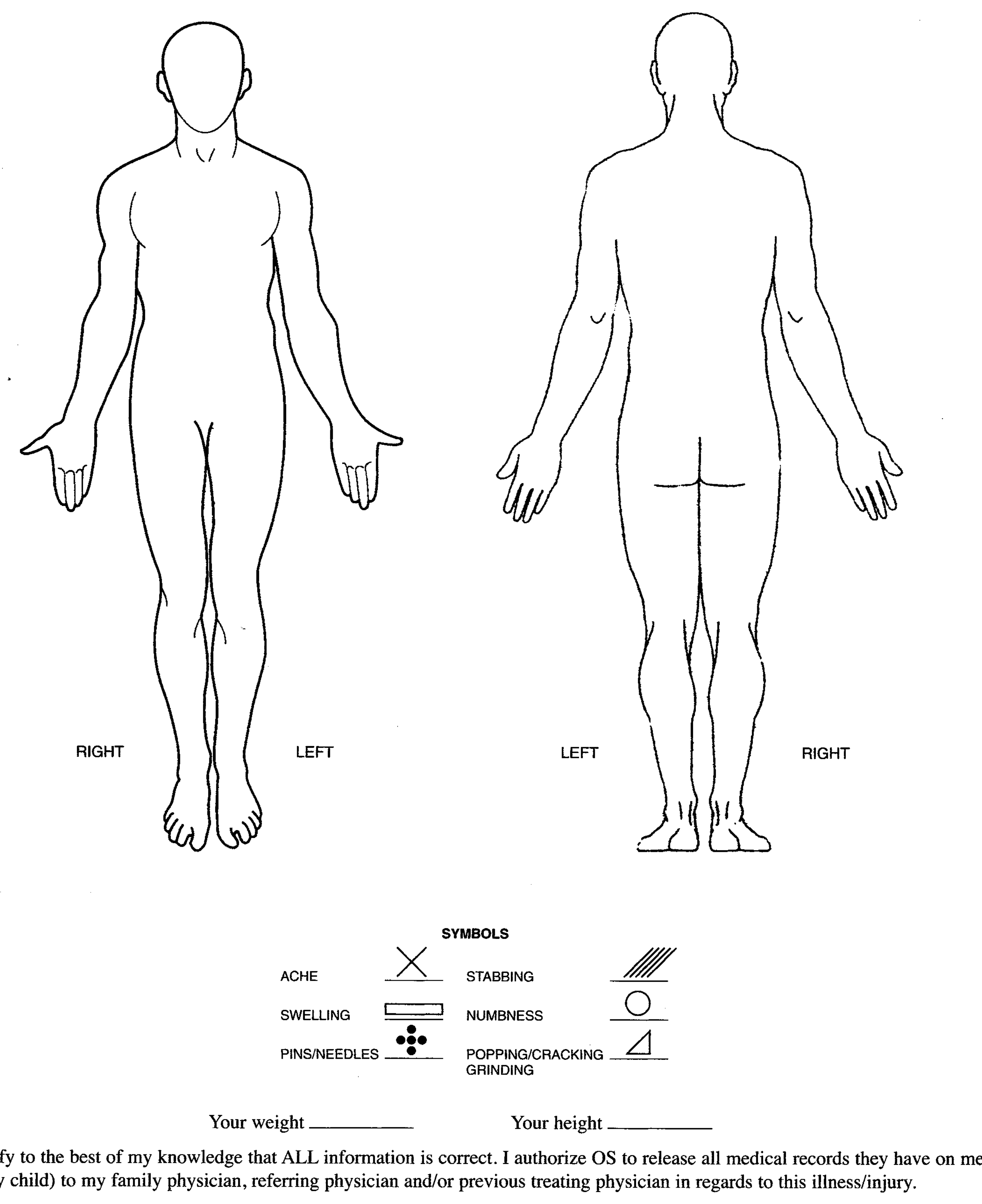
DIAGRAM (mark the parts of your body where you feel the problem. Use the appropriate symbols indicated below).



Your weight __________ Your height __________

I certify to the best of my knowledge that ALL information is correct. I authorize OS to release all medical records they have on me (or my child) to my family physician, referring physician and/or previous treating physician in regards to this illness/injury.

Signed: ______________________________ DATE ______________________________

Patient (unless a minor)