



Patient Medical History Form

Patent Name: _____ **Date of Birth:** _____

Height: _____ **Weight:** _____ **Preferred Pharmacy:** _____

Primary Provider: _____ **Referred By:** _____

Please List all current Medications & Supplements: (Name, Dose, Frequency, Reason) .

Are you taking prescribed Blood Thinners? Yes No If yes, Specify _____

Are you taking any GLP-1 (Semaglutides)? Ex. Ozempic, Trulicity, Monjaro, Wegovy Yes No

Do you have any history of the following? (Check all that apply)

- | | |
|---|--|
| <input type="radio"/> Alcohol Dependency | <input type="radio"/> Kidney Disease |
| <input type="radio"/> Aneurysm Where: | <input type="radio"/> Kidney Stones |
| <input type="radio"/> Arthritis: Rheumatoid / Osteo | <input type="radio"/> MRSA Infection |
| <input type="radio"/> Asthma/Breathing Problems | <input type="radio"/> Narcotic Dependency |
| <input type="radio"/> Bone or Joint Infections | <input type="radio"/> Pacemaker |
| <input type="radio"/> Congestive Heart Failure | <input type="radio"/> Pulmonary Embolism |
| <input type="radio"/> COPD | <input type="radio"/> Reaction to Anesthesia Type: |
| <input type="radio"/> Deep Vein Thrombosis | <input type="radio"/> Sleep Apnea |
| <input type="radio"/> Emphysema | <input type="radio"/> Stomach Ulcers/Reflux |
| <input type="radio"/> Epilepsy/Seizures | <input type="radio"/> Stroke/TIA |
| <input type="radio"/> GERD/Reflux | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Heart Attack | |
| <input type="radio"/> Hepatitis Type: | |
| <input type="radio"/> High Cholesterol | |
| <input type="radio"/> HIV/AIDS | |
| <input type="radio"/> Hypertension | |
| <input type="radio"/> Hyperthyroidism | |
| <input type="radio"/> Hypothyroidism | |

Do you have any allergies: Yes No If Yes, Please list below with reaction (rash, hives, etc.)

Please list all previous surgeries:

- Appendectomy
- Cataract Surgery
- Cholecystectomy (Gallbladder)
- Heart Surgery
- Hernia Repair
- Hysterectomy
- LAP Band/Gastric Bypass
- Lumpectomy
- Cancer
- Mastectomy
- Pacemaker
- Stents
- Tonsillectomy
- OTHER:

Please list any direct family members that have had any of the following disorders.

(Mother, Father, Brother, Sister, Child) Diabetes, Heart Disease, Hypertension, Bleeding Problems, Epilepsy, Muscular Dystrophy, Stroke, Osteoporosis, Rheumatoid Arthritis, Cancer, Deep Vein Thrombosis, Pulmonary Embolism, Early Cardiac death, Bleeding disorder, Anesthesia problems.

Family Member _____ Disorder _____

Family Member _____ Disorder _____

Family Member _____ Disorder _____

Family Member _____ Disorder _____

Family Member _____ Disorder _____

Family Member _____ Disorder _____

Family Member _____ Disorder _____

Family Member _____ Disorder _____

Social History: (Please circle)

Dominate Hand: Right Left Ambidextrous

Alcohol Consumption: Yes No If yes, how many drinks per week? _____

Smoke/Chew Tobacco: Yes No If yes, how often? _____

(Fill in if applicable)

Current Occupation: _____ **Retired From:** _____

Current School/Grade: _____

Today's visit: Body Part _____ Left Right Both

Details: _____

Symptoms: (Circle)

Pain Numbness/Tingling Fracture Stiffness Other: _____

Does the pain radiate? Yes No If Yes, describe _____

Rate the Pain from 0-10 (10 being the worst) _____ **Constant?** Yes No

Getting worse or better? _____ **Affecting your sleep?** Yes No

Is your problem a result of an injury or accident? Yes No

If yes, how did the injury occur? _____

Date of injury/ Onset Date (mm/dd/yyyy) _____

Auto Accident? Yes No **Work Related Injury?** Yes No

If yes, list your Worker's Compensation Physician: _____

Have you been seen in an ER for this problem? Yes No If yes, name the facility and date of service: _____

Have you had any prior tests for this problem? (x-ray, MRI, etc.) Yes No

If yes, list the test, date & facility: _____

Have you had any prior treatment for this problem? (ice, heat, bracing, medication, etc.) Yes No

If yes, list the type of treatment, date and effectiveness: _____

Please check if you have experienced any of the following in the last 6 months:

- Heartburn, ulcers
- Nausea, Vomiting
- Blood in Stool
- Fever
- Heat or Cold Intolerance
- Night Sweats
- Weight Loss
- Loss of Appetite
- Fatigue
- Blurred Vision
- Double Vision
- Vision Loss
- Hearing Loss
- Hoarseness
- Trouble Swallowing
- Chest Pain
- Palpitations
- Chronic Cough
- Pneumonia
- Shortness of breath
- Painful Urination
- Blood In Urine
- Kidney Problems
- Frequent Rashes
- Frequent Falls
- Loss of Coordination
- Dizziness
- Depression/Anxiety
- Drug/Alcohol Addiction
- Sleep Disorder
- Easy Bleeding
- Easy Bruising
- Anemia
- Other _____
- Other _____
- Other _____

Patient/Guardian Signature

Date _____

