MEDICAL HISTORY & REVIEW OF SYMPTOMS: Please check all that apply

Do you now or have you had any problems related to the following systems?

| Past Medical History | Past Surgeries | Medications (please list) |
|--|--|---|
| Please check off/list all medical problems | ☐ Tonsillectomy ☐ Appendectomy | mg |
| ☐ High blood pressure | □ Heart bypass □ Gall Bladder | |
| ☐ High cholesterol | ☐ Hysterectomy ☐ Hip replacement | |
| ☐ Heart problems | ☐ Knee replacement ☐ Rotator cuff repair | |
| □ Diabetes | | |
| ☐ Lyme Disease ☐ Lung Disease | | □ mg |
| | | |
| | | |
| Height: Weight: | | ALLERGIES: |
| Height: Weight: | | |
| Skin | Endocrine/Hematologic/Immunologic | Musculoskeletal |
| □ itching/dryness | □ excessive thirst | □ joint stiffness/pain/swelling |
| □ rashes | ☐ frequent urination | □ arthritis |
| □ bruising | □ appetite change | □ fibromyalgia |
| □ breast disease | □ heat or cold intolerance | □ None of the above |
| □ None of the above/negative | □ diabetes | a real of the doore |
| a remote the week of magnitive | □ thyroid problems | General (Constitutional) |
| | □ osteoporosis | |
| | □ bleeding disorder | ☐ significant weight gain/loss (circle one) |
| | □ anemia | □ fever |
| | □ blood transfusion | □ chills |
| | □ cancer | □ None of the above/negative |
| | □ None of the above/negative | |
| Psychological | Eyes, ears, nose and throat | Respiratory |
| □ anxiety | □ double vision | □ shortness of breath |
| □ depression | □ glasses/contacts | □ asthma or wheezing |
| □ nervousness | □ poor hearing | □ frequent or chronic cough |
| □ None of the above/negative | □ frequent nose bleeds | □ COPD (emphysema) |
| _ | □ sore throats | □ coughing up blood |
| Genitourinary | □ hoarseness | □ coughing up phlegm |
| urinary tract infections | □ sinus infections | □ tuberculosis |
| □ kidney stones | □ None of the above/negative | □ None of the above/negative |
| □ prostate disease | | |
| □ None of the above/negative | | |
| a rone of the doors, negative | | |
| Cardiovascular | Neurologic | Gastrointestinal |
| □ high blood pressure (hypertension) | □ stroke | □ abdominal pain |
| □ heart attack | □ seizures | □ nausea/vomiting |
| □ heart murmur | □ dizziness | □ diarrhea |
| □ chest pain or angina | □ speech difficulties | □ constipation |
| □ palpitations | □ numbness or tingling | □ vomiting blood |
| □ breathlessness | □ paralysis | □ hemorrhoids |
| □ edema (swelling of feet/ankles) | □ migraine headaches | □ bloody stool |
| □ peripheral vascular disease | □ None of the above/negative | □ reflux □ ulcers □ heartburn |
| □ phlebitis | | □ hepatitis |
| □ blood clots | | □ gall stones |
| □ arrhythmia/irregular heart beat | | □ irritable bowel syndrome |
| □ pacemaker/defibrillator | | □ None of the above/negative |
| □ high cholesterol | | |
| □ None of the above/negative | | |
| | | |
| Patient signature | Print name | Date |
| | | |

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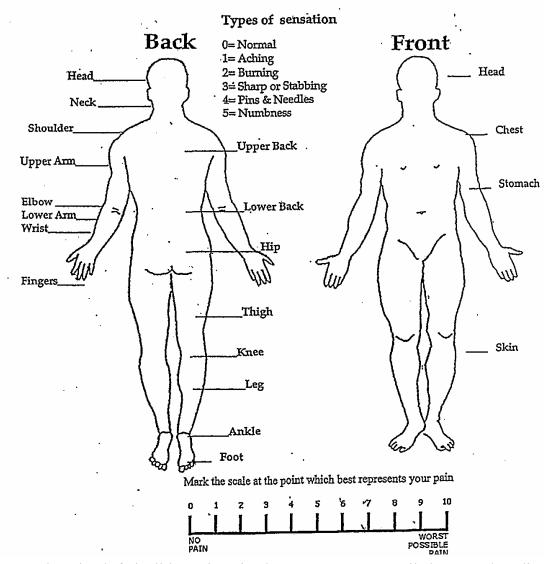
Reviewed by: Date Reviewed for H&P:

| Work Status | Family History | Social History |
|--|--------------------------------------|--------------------------------------|
| Is your injury a result of a | Is your mother living? □Yes □ No | Do you smoke? □Yes □ No |
| Car accident? □ Yes □ No | List medical problems/cause of death | |
| Work injury? □ Yes □ No | | # packs/day# of years |
| Date of injury: | | |
| Occupation: | | Quit smoking |
| □ sedentary □ heavy labor | Is your father living? □Yes □ No | |
| □ physically demanding without lifting | List medical problems/cause of death | Do you drink alcohol? □Yes □ No |
| How long have you been out of work? | | |
| Back Injury(ck one) | | How much? |
| Attorney | | |
| | | Do you have a living will? □Yes □ No |

 Primary Care Physician:
 Tel #:

Mark where you have pain or numbness on the drawings of the front and back of the body. If the pain or numbness goes down your arm(s) or leg(s), show how far the sensation travels.

Then, from the list of types of sensation below, print the number next to the part of the body that describes the type of sensation you have at each location. If you have more than one sensation in a particular location choose the sensation that occurs most often.



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