MEDICAL HISTORY

Patient Name:_____ **Date:**_____

Age:_____ **Height:**_____ **Weight:**_____ **Shoe Size:**_____

List of Allergies:_____

List of Current Medications:_____
Pharmacy name: _____**Phone#**_____
Address: Street _____ **City** _____

Ever had any surgeries, please list: _____

_____

Family History of : **Diabetes** **Yes No Don't know**
Heart Problems **Yes No Don't know**
Other:_____

HABITS: **Smoking □Never □Former Smoker □Current Smoker ___Packs/Day X ___Years**
Alcohol ____None ____□Occasional ____# of Drinks/Day or Drinks/Week
Drugs ____None ____□Yes Specify _____
IMMUNIZATION: Did you get a flu shot this past season? ____□Yes ____No
FEMALE: Are you pregnant? ____ Yes ____ No ____ Not sure

HISTORY OF PRESENT ILLNESS-NEW CHIEF COMPLAINT

Describe in detail the reason for your visit today:_____
_____
_____
_____

Was this complaint the result of a work related injury?_____

How long has this condition existed?_____

Is this condition painful?_____

If so, what is the pain level on a scale of 1-10 (10 being the worst)?_____

Describe the pain (i.e. sharp, shooting, dull, tingling)?_____

Have you tried anything to relieve the pain (i.e. OTC meds, Rx meds, ice, heat)?_____

_____**Did it help? Yes/No**_____

Have you received treatment somewhere else for this problem? If yes, please give details:_____
_____