

MEDICAL HISTORY FORM

Name _____ Date _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____ SS/Medicare Number _____

Home Phone _____ Cell Phone _____ Work Phone _____

Gender M F Married Y N Spouse's Name _____

Emergency Contact Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Medical Doctor Name _____ Phone Number _____

Main Problem

What pain causes you to come to the office? _____

What caused this pain? _____

When did this pain start? _____ How long does this pain last? _____

How bad is this pain? (Circle the one that applies) Mild, Moderate, Severe, Intolerable

Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse,
Lighteninglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike

How often does the pain occur? (Circle the one that applies) Occasional, Frequent, Constant

Does this pain travel to any other area? _____

What makes this pain better? _____

What makes this pain worse? _____

What else have you done to treat this pain? _____

Other Problem

What other pain do you have? _____

What caused this pain? _____

When did this pain start? _____ How long does this pain last? _____

How bad is this pain? (Circle the one that applies) Mild, Moderate, Severe, Intolerable

Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse,
Lighteninglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike

How often does the pain occur? (Circle the one that applies) Occasional, Frequent, Constant

Does this pain travel to any other area? _____

What makes this pain better? _____

What makes this pain worse? _____

What else have you done to treat this pain? _____

Date _____

Family History

Please tell us about the health of you parents, siblings and children. Circle or check everything that applies. If someone is deceased, please check or write in the cause.

		Living/Deceased	Heart disease	Stroke	Cancer	Diabetes	Rheumatoid Arthritis	Multiple Sclerosis	Lung Disease	Bone Disease
Father	L D Cause:									
Mother	L D Cause:									
Sibling M Child F	L D Cause:									
Sibling M Child F	L D Cause:									
Sibling M Child F	L D Cause:									
Sibling M Child F	L D Cause:									
Sibling M Child F	L D Cause:									
Sibling M Child F	L D Cause:									
Sibling M Child F	L D Cause:									

Past and Social History

Are you employed Y N Where _____ How is your health? _____

Do you Drink alcohol Y N Use tobacco Y N Use recreational drugs Y N

Have you had any illnesses in the past _____

Have you had any injuries _____

Have you been hospitalized _____

Have you had any surgeries _____

List any medications that you are taking _____

I certify that the information that the information that I have given here is true and accurate to the best of my knowledge.

Signed _____ Date _____