MEDICAL HISTORY FORM

Name____ Date_______________________

Date of Birth____________________

Medical Doctor Name___________________________ Phone Number_____________________________

List all known allergies____

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? ____

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 Child M or F	L D Cause:								
Sibling Child M or F	L D Cause:								
Sibling Child M or F	L D Cause:								
Sibling Child M or 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_________________________