PATIENT MEDICAL HISTORY FORM

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Last Name	**First**	☐ M ☐ F	**DOB:**
What brings you here today?		**Height:**	**Weight:**
Occupation:	**Employer:**		
Do You Smoke? ☐ Yes ☐ No	Packs per day?		
Do You Drink Alcohol? ☐ Yes ☐ No	Drinks per week?	Are you pregnant? ☐ Yes ☐ No	

PERSONAL HEALTH HISTORY

Have you ever been diagnosed or treated for: (check all that apply) ☐ **Check here if no medical problems**

☐ High Blood Pressure	☐ Diabetes	☐ Gout	**Date of Current Illness/Injury: / /**
☐ Heart Attack	☐ Stomach Ulcer	☐ Osteoarthritis	First Date of similar illness/injury: / /
☐ Congestive Heart Failure	☐ Thyroid Disease	☐ Rheumatoid Arthritis	☐ Condition related to Employment
☐ Heart Disease	☐ Emphysema	☐ Cancer (what type?)	☐ Condition related to Auto Accident / Accident State____
☐ Stroke	☐ Kidney Disease	☐ GI Bleeding	☐ Condition related to Other Accident
☐ Head Injury	☐ Visual Problems	☐ Fractures	Dates unable to Work from current illness/injury:
☐ Seizures	☐ Balance Problems	☐ Neck Pain / Injury	From: / / To: / /
☐ Other _____	☐ Difficulty Walking	☐ Back Pain / Injury	Dates Hospitalized from current illness/injury:
☐ Other _____	☐ Other _____	☐ Joint Pain / Problem	From: / / To: / /

What medications are you taking currently? ☐ None	**Have you had any prior surgery / treatment? *☐Yes ☐No***
1:	When Type of surgery / treatment?
2:	
3:	
4:	

Have you experienced any of the following within the last 3 months? ☐ **None** (Check here if none)

General	**Respiratory**	**Hematologic**
☐ Fever	☐ Painful Breathing	☐ Anemia
☐ Chills	☐ Unusual Shortness of Breath	☐ Tendency to bruise easily
☐ Night Sweats	☐ Cough	☐ Blood clots in legs
☐ Fatigue	☐ Previous Exposure to Tuberculosis	
Cardiovascular	**Musculoskeletal**	**Integumentary**
☐ Chest Pain	☐ Joint Stiffness	☐ Rashes or spots
☐ Palpitations	☐ Joint Swelling	☐ Sudden changes in moles or growths
☐ Swollen Feet\Legs	☐ Limited Joint Motion	☐ Itching or Redness
☐ Difficulty breathing while lying in bed	☐ Abnormal Masses or Bumps	☐ Excessive Sweating
☐ Pain in legs while walking		☐ Abnormal Hair or Nail Growth
Genitourinary	**Gastrointestinal**	**Neurological**
☐ Pain with Urination	☐ Abdominal Pain	☐ Seizures
☐ Flank or Back Pain	☐ Heartburn\Indigestion	☐ Numbness or Tingling
☐ Unusually Frequent or Urgent Urination	☐ Nausea	☐ Sudden Weakness
☐ Difficulty Starting Urinary Stream	☐ Vomiting	☐ Tremors
☐ Kidney Stones	☐ Diarrhea	☐ Memory Loss
	☐ Bloody Stools	☐ Unusual \Severe Headaches

Client Signature:	**Date:**

For Office Use Only Diagnosis:

ICD9 Codes: