

Date: \_\_\_\_\_ Chart # \_\_\_\_\_

*Please ask for assistance if you have any questions while entering your medical history.*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**TODAY'S CHIEF COMPLAINT:** \_\_\_\_\_ **Left Right Bilateral**

Did you have an injury? \_\_\_\_\_ Where? \_\_\_\_\_ When? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Work related? **Yes / NO STOP – BE CERTAIN WORK COMP PROCEDURES ARE IN PLACE!**

**PAST MEDICAL HISTORY** \_\_\_\_\_ **I have NO MEDICAL HISTORY**

Diabetes	Y / N	Heart Condition	Y / N	Anxiety/Stress Issues	Y / N
Stroke	Y / N	Peptic Ulcer Disease	Y / N	Cholesterol	Y / N
High Blood Pressure	Y / N	Blood Clots	Y / N	Asthma	Y / N
Hepatitis B Hep C	Y / N	Anesthesia Complications	Y / N	Bleeding Disorders	Y / N
TB	Y / N	HIV/ AIDS	Y / N	Acid Reflux/Heartburn	Y / N
Cancer, if yes, Type _____	N	Thyroid disease	Y / N	Glaucoma	Y/N
Pacemaker	Y / N	<b>Insulin Pump</b>	Y / N	<b>Other implantable devices?</b> _____	

**PAST SURGICAL HISTORY** \_\_\_\_\_ **I have not had any surgeries.**

<u>Surgeries/Hospitalizations</u>	<u>Year</u>	<u>Complications</u>
_____	_____	_____
_____	_____	_____

Do you use tobacco products? **No NEVER Yes, Type** \_\_\_\_\_ **If yes, how much?** \_\_\_\_\_ **How long?** \_\_\_\_\_ **# of years quit** \_\_\_\_\_

Do you drink alcoholic beverages? **Yes / No NEVER** **If yes, how often, how much?** \_\_\_\_\_

Do you have a history of drug abuse or addiction? **Yes / No NEVER** **If yes, to what?** \_\_\_\_\_

**FAMILY HISTORY** – **Please tell us what conditions or chronic illnesses are in your family. Include Diabetes, High Blood Pressure, Cardiac conditions, Respiratory conditions, cancers, bleeding disorders, anesthesia complications:** \_\_\_\_\_

**Optional: Spiritual History**  
Your church affiliation: \_\_\_\_\_  
You put your faith in \_\_\_\_\_  
\_\_\_\_ I rely on prayer  
\_\_\_\_ I would like to understand how my faith affects my health  
\_\_\_\_ I would like to know more about the Christian faith.

Patients Please Note: This information is extremely important. The clinical staff will review this form with you and if any changes or additions are needed, you will be asked to initial them on this form.

By initialing here, I certify that I have reviewed this information with the patient/guardian and it is correct as stated. Any corrections or additions to the Patient's original entries have been initialed by the patient.

\_\_\_\_ Nurse Interviewer      Physician Statement: I have reviewed this information with patient as a part of today's examination. \_\_\_\_\_

