

# Medical History Form

Patient Name: \_\_\_\_\_ Latex Allergies: Yes \_\_\_ No \_\_\_ Topical Allergy: \_\_\_\_\_

Height: \_\_\_\_\_ ft \_\_\_\_\_ in Weight: \_\_\_\_\_ (pounds) Date of injury: \_\_\_\_\_

Diagnosis as stated to you by your physician: \_\_\_\_\_

How did this injury/ exacerbation occur? \_\_\_\_\_

Have you been hospitalized for the present condition? ☐ Yes ☒ No If Yes, date: \_\_\_\_\_

Have you had surgery for the present condition? ☐ Yes ☐ No If Yes, date: \_\_\_\_\_

If yes, surgery type: \_\_\_\_\_

Have you had any falls this past year? ☐ Yes ☐ No If Yes, how many? \_\_\_\_\_

Have you received previous treatment for this condition? ☐ Yes ☐ No If Yes, date: \_\_\_\_\_

If yes, please summarize: \_\_\_\_\_

Have you ever had any of the following? ☐ EMG ☐ CT SCAN ☐ MYELOGRAM ☐ MRI ☐ XRAY

Have you ever, or are you presently being treated for any of the following conditions?

Acquired Respiratory Distress Syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety or Panic Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis (RA, OA)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congestive Heart Failure (CHF)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Degenerative Disc Disease (back disease, spinal stenosis, severe chronic back pain)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Parkinson's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Peripheral Vascular disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke or TIA	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Upper Gastrointestinal Disease (ulcer, hernia, reflux)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Visual Impairment (cataracts, glaucoma, macular degeneration)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bowel / Bladder Abnormalities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizzy or Fainting Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy or Seizure Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fracture	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis A, B, C	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypoglycemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Immunosuppressant Condition or Medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver / Gallbladder Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Metal Implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nausea / Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ring in Your Ears	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sexual Dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skin Abnormalities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Smoking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Special Diet Guidelines	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No

# Sample Primary Care Medical History Template

**L Towne**



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