Medical History

Name: _____ Date: _____

Date of Birth: _____

Main Complaint (Reason for visit): _____

_____

_____

Date Symptoms Started: _____

How did this problem begin? _____

_____

What makes it better? _____

Worse? _____

Have you had a similar condition? _____

What treatment have you received and by whom? _____

_____

Is this visit for a second opinion only? ❑ Yes ❑ No (Provide opinion or advice only)

If so, who referred you? _____ When? _____

Diagnostic Testing (MRI, CT scan, EMG, X-Ray, Bone Scan, etc.)

Test Date Facility

_____

_____

_____

_____

Accidents: (Car accidents, work accidents, etc.)

Date: Brief Description:

_____

_____

_____

Past Medical History (Illness you have had)

❑ Heart Disease Cardiologist Name: _____ Phone (_____) _____

❑ Diabetes ❑ Migraine Headaches ❑ Asthma ❑ Aids

❑ High Blood Pressure ❑ Seizures When? _____ ❑ Bleeding Problems ❑ Hepatitis

❑ Cancer Type: _____ ❑ Kidney Problems ❑ Thyroid

Other Illnesses/Hospitalizations:

1._____
2._____
3._____
4._____
5._____

Operations (include dates):

1._____
2._____
3._____
4._____
5._____

Medications (include dosage):

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Medication Allergies: ❑ Yes, List ❑ No

1._____
2._____
3._____
4._____

Allergic to **adhesive tape**? ❑ Yes ❑ No

Allergic to **latex**? ❑ Yes ❑ No

***** Do you need more room here?**