Medical Information Sheet

Patient Name (Print) _____DOB: _____

1) List all current medications & dosages including over the counter medications or write none:

_____

_____

_____

2) List any allergies or intolerances to medications and your reaction to them or write none:

_____

_____

3) List any medical conditions for which you are being treated (such as diabetes, cancer, high blood pressure, or cardiac disease) or write none:

_____

_____

4) List any past surgeries: _____

_____

5) List your primary care physician & address if not local:_____

_____

6) List height_____ Weight_____ Last Tetanus_____

Social History

1) List weekly use of alcohol products (beer, wine, liquor) or write none:

_____

2) List any "street" or recreational drug use or write none: _____

3) List daily use of cigarettes or other tobacco products or write none:_____

4) Present Occupation: _____

5) Are you presently disabled from work? _____

6) If retired or currently not working, list past occupation:_____

Patient Name (Print) _____DOB: _____

7) Level of education (last grade completed or degree):_____

8) Do you exercise regularly, if so what type? _____

Family Health History

Mother: If alive, any health problems? _____

If deceased, cause of death?_____

Father: If alive, any health problems? _____

If deceased, cause of death?_____

Siblings: any health problems?_____

Children: any health problems? _____

Hereditary Diseases: Is there any family history of diabetes, hemophilia (bleeding), sickle cell disease, cystic fibrosis, sudden death during anesthesia, high blood pressure, tuberculosis, epilepsy, or any other familial diseases? If so please elaborate or write none.

_____

_____

Pain Survey

Please indicate your pain score using the numeric pain scale from 0-10. 0 indicates no pain 10 is the worst possible pain: Back_____ Neck_____ Leg_____ Arm_____

Do any of the following activities make you feel better?
Lying down Yes____ No____ Standing Yes____ No____ Sitting Yes____ No____
Exercise Yes____ No____ Walking Yes____ No____

Is your pain aggravated by any of these? (Check for yes)

____ Coughing or sneezing ____sitting in a chair ____When you wake up
____ bending forward to brush teeth ____Walking a distance
____ lying flat on your back ____Lying with your knees apart
____ In the middle of the night

What was the cause of your pain? Housework____ Work Injury____ Sports____ Other____
Have you had similar attacks in the past? No____ 1-2____ 3-5____ 5 or more____

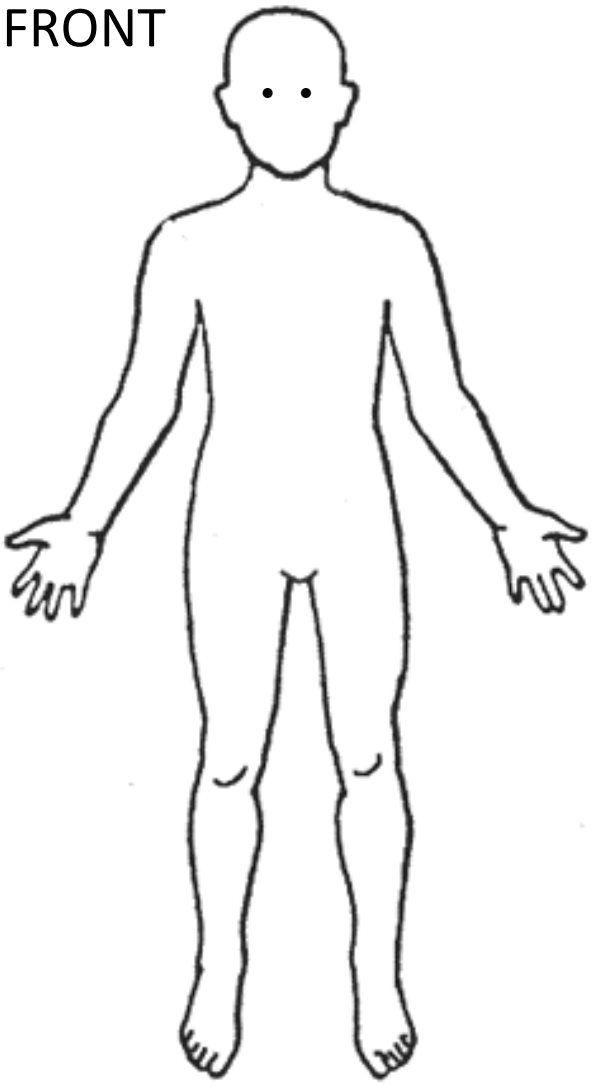
Patient Name (Print) _____DOB: _____Visit Date: _____

Using these symbols mark the area on your body where you feel the described sensations.

XXXX Burning !!!! Stabbing ****Pins and Needles

OOOO Aching >>>> Numbness ???? Other

FRONT



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