

MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____ Date of Injury/Onset: _____
 Allergies: _____
 Emergency Contact: _____ Phone _____
 Are you pregnant? Y / N Please list any test results (X-ray, MRI, etc): _____
 Referring MD: _____ Phone: _____ Primary Care MD: _____ Phone: _____
 Current Medications: _____

 Other MD/phone (Please list *any* other MD who is prescribing or who you are receiving care from): _____

Do you have any past or present history of:	Yes	No
Heart Disease, High Blood Pressure, Angina, Pacemaker?	_____	_____
Respiratory Problems, Asthma, Allergies, TB?	_____	_____
Diabetes (Any type)?	_____	_____
Arthritis(Diagnosed by M.D.)?	_____	_____
Bone Disease(s)	_____	_____
Skin Disorders, Eczema, Psoriasis, Athlete's foot?	_____	_____
Communicable Diseases, hepatitis, TB?	_____	_____
History of Cancer (Any type)?	_____	_____
Psychiatric history	_____	_____
Any metal or artificial implants?	_____	_____
Any previous injuries to the same area?	_____	_____
Any previous motor vehicle accidents with injuries?	_____	_____
Any previous surgeries?	_____	_____
Any history of seizures or epilepsy?	_____	_____
Do you have any latex allergies?	_____	_____

Please explain any YES answers and state date of occurrence:

In the diagram on the right, please mark the area(s) where your pain is located using the following symbols:

- X = PAIN**
- /// = PINS AND NEEDLES**
- O = NUMBNESS**
- ↓ = SHOOTING PAIN**

Please rate your pain right now on a scale of 0 – 10 with 0 being no pain at all and 10 being the worst pain imaginable:

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
 What would you rate your pain at its lowest? /10
 What would you rate your pain at its highest? /10

Please describe your pain (circle all that apply).
 constant intermittent sharp dull aching burning
 tingling stabbing throbbing shooting cramping

Do you have a Do Not Resuscitate (DNR) Order?
 Yes _____ No _____ NA _____

Signature: _____ **Date:** _____

