MDWest ONE, PC **Interim Medical History**

Interim Medical History

Patient Name: _____ **Sex:** ☐ Male ☐ Female

DOB: _____ **Age:** _____ **Height:** _____ **Weight:** _____

Visit Information

Reason for Visit: _____ Symptoms started: ___/___/___

Pain Quality: ☐ Dull / Ache ☐ Sharp / Stabbing ☐ Throbbing ☐ Shooting ☐ Pressure ☐ Electric ☐ Click / Pop

Severity: None ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ Intolerable ○ Duration of Pain: _____ Location of Pain: _____ ☐ R ☐ L

Pain Aggravated By:

☐ Standing ☐ Walking ☐ Lying ☐ Stooping
☐ Sleeping ☐ Working ☐ Stairs ☐ Bending
☐ Sitting ☐ Driving ☐ Lifting ☐ Turning

Treatments Attempted: ☐ **NONE** ☐ **Other** _____

☐ Pain Medications ☐ Anti-Inflammatory ☐ Rest
☐ Wheelchair ☐ Physical Therapy ☐ Ice
☐ Injections/ESI ☐ Chiropractic Care ☐ Surgery

Past Medical History

Please note all health issues you are currently experiencing

☐ Heart Disease ☐ Pacemaker/Defibrillator ☐ Kidney Disease ☐ Stomach Ulcers ☐ DVT (Blood Clots)
☐ Malignant Hyperthermia ☐ Lung Disease ☐ Diabetes ☐ Recurrent Infections ☐ Depression
☐ Hypertension ☐ Pulmonary Embolism ☐ Arthritis ☐ HIV/AIDS/Hepatitis ☐ Liver Disease
☐ Cancer _____ ☐ Other _____

Recent Surgical History ☐ NO CHANGES SINCE LAST VISIT

Please list all previous surgeries and approximate dates of surgery

Surgery:	Date:	Surgery:	Date:
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___

☐ History of anesthesia reaction (describe): _____

Medications ☐ NO CHANGES SINCE LAST VISIT

Please list all current medications including over-the-counter medications, vitamins, herbal supplements, and prescribed drugs

Medication:	Dose:	Medication:	Dose:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies ☐ NO CHANGES SINCE LAST VISIT

Known Drug Allergies:

☐ Latex ☐ Shellfish ☐ Diagnostic Dyes ☐ Metal ☐ Codeine ☐ Acetaminophen ☐ Aspirin
☐ Antibiotics (please list) _____
☐ Other _____

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Social History ☐ NO CHANGES SINCE LAST VISIT

Occupation ☐ Employed: _____ ☐ Retired _____
☐ Disabled Reason for Disability: _____
Do you currently live alone? ☐ No ☐ Yes - Relationship: _____
Have you ever been a smoker? ☐ No ☐ Yes - _____ Packs / Day Quit: _____ Months Ago _____ Years ago
Do you drink alcohol? ☐ No ☐ Yes - ☐ Social ☐ Moderate - 1-2 drinks/day ☐ Frequent - 3 or more drinks/day
Any recreational drug use? ☐ No ☐ Yes - Please List: _____

Family History ☐ NO CHANGES SINCE LAST VISIT

Please note health issues affecting mother, father, sister or brother and indicate which family member is affected

☐ Blood Clots _____ ☐ Aneurysm _____ ☐ Arthritis _____ ☐ Other _____
☐ Heart Disease _____ ☐ Stroke/TIA _____ ☐ Hip Disorders _____ ☐ Cancer - Type: _____
☐ Respiratory Disorders _____ ☐ Diabetes _____ ☐ Autoimmune _____ Family Member: _____
☐ High Blood Pressure _____ ☐ Neurological Disorders _____ ☐ Malignant Hyperthermia _____

Other important health information: _____

Review of Systems (Check all that apply)

Constitutional	☐ Weight Loss	☐ Weight Gain	☐ Fatigue	☐ Decreased Appetite
	☐ Chills	☐ Fever	☐ Night Sweats	
Eyes	☐ Blurred Vision	☐ Vision Loss	☐ Eye Pain	☐ Eye Redness
	☐ Double Vision	☐ Glasses	☐ Contacts	
Ear, Nose & Throat	☐ Hearing Loss	☐ Ringing in the Ear	☐ Sinus Pressure	☐ Sore Throat
	☐ Swollen Glands			
Cardiovascular	☐ Chest Pain	☐ Palpitations	☐ Hand/Foot Swelling	☐ Leg Pain w/ Walking
Respiratory	☐ Cough	☐ Wheezing	☐ Snoring	☐ Shortness of Breath
Gastrointestinal	☐ Nausea/Vomiting	☐ Diarrhea	☐ Constipation	☐ Abdominal Pain
	☐ Stool Incontinence			
Genitourinary	☐ Burning w/ Urination	☐ Urinary Frequency	☐ Urinary Urgency	☐ Blood in Urine
	☐ Urinary Incontinence			
Musculoskeletal	☐ Bone Pain	☐ Muscle Pain	☐ Joint Pain	☐ Joint Swelling
	☐ Arm Pain	☐ Arm Weakness	☐ Leg Pain	☐ Leg Weakness
Integumentary	☐ Skin Rash	☐ Itching	☐ Hives	
Neurologic	☐ Headaches	☐ Weakness	☐ Numbness	☐ Memory Loss
	☐ Tingling	☐ Balance Difficulty	☐ Seizures	☐ Poor Arm/Leg Coordination
Psychological	☐ Depression	☐ Anxiety	☐ Irritability	☐ Sleep Disturbance
	☐ Suicidal Ideation			
Endocrine	☐ Heat Intolerance	☐ Excessive Thirst	☐ Excessive Hunger	
Hematologic	☐ Easy Bleeding	☐ Easy Bruising	☐ Bleeding Disorders	
Immunological	☐ Seasonal Allergies	☐ Recurrent Infections		

Please list all specialists participating in your care:

Provider	Condition

Signature

Patient Signature _____ **Date** _____