MDWest ONE, PC — Adult Medical History

Medical History Information Sheet

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

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

Visit Information

Primary Care Physician: _____ Referring Physician: _____

Reason for Visit: _____ Date of Injury: ___/___/___

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 ☐ Liver Disease ☐ Chronic Headaches
☐ Malignant Hyperthermia ☐ Lung Disease ☐ Diabetes ☐ Hepatitis/Jaundice ☐ Thyroid Problems
☐ Hypertension ☐ Pulmonary Embolism ☐ Rheumatoid Arthritis ☐ Stomach Ulcers ☐ HIV/AIDS
☐ DVT (Blood Clots) ☐ Asthma ☐ Osteoarthritis ☐ Recurrent Infections ☐ Other _____
☐ High Cholesterol ☐ Depression ☐ Gout ☐ Cancer _____

Surgical History ☐ NONE

Please list all previous surgeries and approximate dates of surgery

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

☐ history of anesthesia reaction (describe): _____

Medications ☐ NONE

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

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

Allergies ☐ NONE KNOWN

Known Drug Allergies:

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

Social History

Occupation Current: _____ ☐ Disabled Reason for Disability: _____
Past: _____ ☐ Retired _____

Do you currently live alone? ☐ No ☐ Yes - Relationship: _____

Have you ever been a smoker? ☐ No ☐ Yes - _____ Packs / Day Quit: _____ Months Ago _____ Years ago

MDWest ONE, PC

Adult Medical History
(15 and older)

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

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	

Review of Systems

Please check all that apply

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

Other important health information: _____

Signature

Patient Signature _____ **Date** _____