Medical History

Patient's name: _____ Date: _____

Date of birth: _____ Social Security #: _____

Is the reason for visit today an injury? □ Yes □ No Date of injury: _____

Accident type: □ Workers' Comp □ Motor Vehicle Accident □ Crime Victim □ Other: _____

Place of injury: □ Home □ Work □ Other: _____

Body Part Injured: _____ □ Right □ Left

Injury Description (example, fell down a flight of stairs and landed on right knee): _____

_____

_____

Concurrent Medical History: □ **Check box if no change since 4/8/14 (if paperwork completed before 4/8/14, must complete this paperwork today)**

Please list any medicines to which you are allergic and the **TYPE OF REACTION** (such as hives, itching, etc):

_____

_____

Pharmacy Name: _____ □ Front Royal or _____

Please list all medications you use for any health reasons, including prescription and non-prescription drugs such as aspirin, Tylenol, ibuprofen, vitamins, Zantac, antacids, laxatives. **INCLUDE DOSAGES AND THE NUMBER OF TIMES YOU TAKE THEM EACH DAY**. Or provide a list for photocopy. **If you provide a photocopy or have brought the original prescription bottles, you do not need to complete the boxes below.**

Medication	Dose	When Taken

Medication	Dose	When Taken

Primary Care Provider: _____

Past Surgical History: □ **Check box if no change since 4/8/14 (if paperwork completed before 4/8/14, must complete this paperwork today)**

Please list any surgeries and include the year done.

_____

_____

_____

T**his section for office staff use only**:

Smoking cessation information provided □ Yes □ No

BP: _____

HR: _____

Weight: _____

Height: _____

Staff Notes: _____

_____

_____

_____

Medical History

Patient's name: _____ DOB: _____ Date: _____

Review of Systems and Family History: Please check if you, your mom, your dad, your brother, or sister have now or may have had in the past. ☐ **Check box if no change since 4/8/14 (if paperwork completed before 4/8/14, must complete this paperwork today)**

	ME	MOM	DAD	BROTHER	SISTER
Asthma					
Blood Disease					
Cancer					
Diabetes					
Heart Disease					
Hypertension					
Kidney Disease					
Liver Disease					
Psychiatric Problems					
Sickle Cell					
Lung Disease					
Arthritis					
Other					

Social History: ☐ **Check box if no change since 4/8/14 (if paperwork completed before 4/8/14, must complete this paperwork today)**

Do you consume alcohol? ☐ Yes ☐ No How much/week? _____ ☐ Wine ☐ Beer ☐ Liquor
Do you use "street drugs"? ☐ Yes ☐ No Any by injection? ☐ Yes ☐ No
Name of "street drug" used: _____
Do you smoke? ☐ Yes ☐ No If yes, how much? _____ How many years? _____
Do you use smokeless tobacco? ☐ Yes ☐ No If Yes, ☐ Chew ☐ Snuff
If you quit smoking, how long ago? _____
Are you ready to quit smoking? ☐ Yes ☐ No
Occupation: _____ Job Duties: _____ Employer: _____
Lives with: _____

The following questions pertain to the patient only: ☐ **Check box if no change since 4/8/14 (if paperwork completed before 4/8/14, must complete this paperwork today). Please check Yes or No.**

	YES	NO	If YES, Please Explain
Activity Change (due to reason here)			
Hearing Loss			
Visual Disturbance (other than wearing glasses)			
Shortness of Breath			
Chest Pain			
Leg Swelling			
Palpitations			
Abdominal Pain			
Diarrhea			
Urinary Urgency			
Gait (walking) Problem			
Joint Swelling			
Headaches			
Seizures			
Syncope (fainting)			
Dysphoric (depressed) Mood			
Nervous/Anxious			