Medical History Form

NAME:______________________________ DATE OF BIRTH:________________ PATIENT ID: ________________

Height:____________ Weight:____________ Age:_____________ Sex: ○ M ○ F

Occupation:___________________________ ☐ Disabled ☐ Retired ☐ Currently Unemployed

Family Doctor:_________________________ Who Referred you to NHOC?__________________________________

Reason for Today's Visit: (which side, right, left, both):____

____

____

When did you start having a problem? ____

Was it related to an accident? ○ No ○ Yes ☐ Work Related ☐ MVA ☐ Other: _________________________

Is there an Attorney involved? ○ No ○ Yes Attorney: ____

Are you currently under treatment at a Pain Management Center? ○ No ○ Yes If yes where? ___________________

Are you currently under a pain contract with anyone? ○ No ○ Yes If yes where and length of time?______________

Patient Medical History

○ Heart Trouble
○ High Blood Pressure
○ Stroke
○ Diabetes
○ Arthritis
○ NONE
○ Gout
○ Seizures
○ Mental Illness
○ Kidney Trouble
○ Osteoporosis
○ Bleeding
○ Alcoholism
○ Serious Injuries
○ Lung Disease
○ Tuberculosis
○ Phlebitis
○ Anemia
○ Stomach Ulcers
○ Liver Trouble
○ Thyroid Trouble
○ Blood Clots/DVT
○ AIDS
○ Hepatitis
○ Cancer
○ Other ________________

Previous Surgeries ☐ NONE	Hospital/Date		Previous Surgeries	Hospital/Date

Known Problems for you with Anesthesia? ○ Yes ○ No If yes please describe:________________________________

Medications

ALLERGIES or Intolerance to Medications: ○ None ○ Yes, If yes please list medication and reactions:

____

____

Latex Allergy/Sensitivity: ○ Yes ○ No

Physician Reviewed:

Initials: ______ **Date:** _____/_____/_____

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Medications you currently take (including over the counter medications, vitamins, herbs, & prescribed drugs):

Medication	Dosage	Medication	Dosage	Medication	Dosage

Family Medical History (Mark if any of these run in your family)

- ○ Heart Trouble
- ○ Stroke
- ○ Arthritis
- ○ Seizures
- ○ Kidney Trouble
- ○ Alcoholism
- ○ High Blood Pressure
- ○ Diabetes
- ○ Gout
- ○ Mental Illness
- ○ Bleeding
- ○ Cancer
- ○ Blood Clots/DVT
- ○ Other: ______________________________

Family history of problems with Anesthesia? ○ No ○ Yes Describe: ______________________________

Social History (Mark if any of these run in your family)

Do you live alone? ○ Yes ○ No Do you exercise regularly? ○ Yes ○ No Describe:__________________

Tobacco Use? ○ Yes ○ No Type: ○ Cigarettes ○Chew # of packs/day____ # of years used:____

Alcohol Consumption? ○ Yes ○ No # of drinks/week:_________ History of Alcoholism? ○ Yes ○ No

Recreational Drug Usage? ○ Yes ○ No Type/Amount/How Often:______________________________

○ Single	○ Married	○ Divorced	○ Separated	○ Widowed
Children:	○ No	○ Yes #____________		
Do you live alone?	○ No	○ Yes	○ One-Story	○ Two-story/steps

Review of Systems **(recent or current conditions)**

- ○ Weight Change
- ○ Fever / Chills
- ○ Night Sweats
- ○ Poor Appetite
- ○ Rash
- ○ Insomnia
- ○ Depression
- ○ Anxiety
- ○ Visual Changes
- ○ Ear Pain / Ringing
- ○ Nosebleeds
- ○ Hoarseness
- ○ Difficulty Swallowing
- ○ Tooth/Gum Trouble
- ○ Chest Pain
- ○ Abnormal Heartbeat
- ○ Blackouts
- ○ Shortness of Breath
- ○ Cough
- ○ Nausea / Vomiting
- ○ Stomach Pain
- ○ Frequent Diarrhea
- ○ Frequent Constipation
- ○ Blood in Stool
- ○ Incontinence
- ○ Urinary Frequency
- ○ Urinary Burning
- ○ Frequent Headaches
- ○ Seizures
- ○ Numbness
- ○ Weakness
- ○ Backache
- ○ Joint Pain
- ○ Joint/Limb Swelling
- ○ Lumps/Masses
- ○ Irregular Periods
- ○ Vaginal Discharge
- ○ Pregnant
- ○ _______________
- ○ _______________

Patient Signature:____ Date:____________________________

Physician Reviewed:

Initials: ______ **Date:** _____/_____/_____