

## YOUR MEDICAL HISTORY page 1

### 1

#### Patient Information

Who referred you to this office \_\_\_\_\_ If patient is a minor, list responsible relative or guardian \_\_\_\_\_

Who is your primary care doctor \_\_\_\_\_ Date \_\_\_\_\_ Phone # \_\_\_\_\_ Work # \_\_\_\_\_

Name \_\_\_\_\_ Cell # \_\_\_\_\_

Date of Birth (M/D/Y) \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Is this visit related to an accident or a work injury? \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Marital Status \_\_\_\_\_ MVA \_\_\_\_\_ Worker's comp \_\_\_\_\_

Home Address \_\_\_\_\_ Is there litigation related to this injury? \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Attorney's Name/Phone # \_\_\_\_\_

Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Insurance company \_\_\_\_\_

Cell # \_\_\_\_\_ Claim # \_\_\_\_\_ Adjuster \_\_\_\_\_

Employer \_\_\_\_\_ Insurance address \_\_\_\_\_

Social Security # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Medical Insurance Primary \_\_\_\_\_ ID # \_\_\_\_\_ Phone # \_\_\_\_\_

Secondary \_\_\_\_\_ ID # \_\_\_\_\_ Do you have an advanced directive (living will)?  Yes  No

Medicare # \_\_\_\_\_ Name of surrogate \_\_\_\_\_

Spouse name \_\_\_\_\_

Spouse employer \_\_\_\_\_

Person to notify in case of emergency \_\_\_\_\_

Phone # \_\_\_\_\_

### 2

#### Medical History

Do you take any medication?  Yes  No

Please list your medications, dosage and schedule \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you take:

Aspirin  Yes  No

Birth control pills  Yes  No

Herbal supplements  Yes  No

Do you have any allergies or adverse reaction to medication or anesthesia? Please list \_\_\_\_\_

\_\_\_\_\_

Please list prior hospitalizations or surgery including reason for hospitalization and dates. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



