Medical History (Part 3 of 3)

Instructions: Please fill out this form to the best of your ability so we can better serve you.

If the question does not apply, write "N/A" or just skip it.

Note: *We apologize there are repeat questions; this is due to HIPAA compliance reasons and keeping medical forms separate for your privacy.*

Full Name

First Name ______ Middle Name ______ Last Name ______

Height

______ ______

Weight

______

Reason for Consultation

______

Current Medications

______

Please check any of the following medications you are currently using:

- Oral Contraceptives
- Aspirin
- Non-Steroidal Anti-Inflammatories
- Estrogen Suppresant (i.e. Tamoxifen, Femara)

Allergies

Hospitalizations or Surgeries

Social History

Have you ever been a smoker?

Yes

No

Are you using any type of nicotine products?

Yes

No

Do you drink alcohol?

Yes

No

Have you had a problem with chemical dependency?

Yes

No

Conditions or Diagnoses

Instructions: Check any conditions that apply. If none apply, just skip the question.

Do you have or have you ever had...

General History

- Recent weight gain
- Recent weight loss
- Recent fever
- Recent fatigue
- AIDS/HIV
- Hepatitis
- Bleeding problem or disorder

____

Eyes, Ears, Nose, Throat

- Migraine
- Neck stiffness
- Disorder of the eyes

____

Respiratory

- Obstructive Pulmonary Disease
- Asthma
- Chronic bronchitis

____

Gastrointestinal

- Hernia
- Vomiting of blood
- Hemorrhoids
- Frequent diarrhea
- Black, tarry stools
- Gallstones
- Pancreatitis
- Frequent nausea or vomiting
- Abdominal pain
- Jaundice
- Chronic constipation
- Bloody stools
- Ulcer
- Hepatitis

____

Endocrine

- Hypo-thyroidism
- Diabetes
- Hyper-thyroidism

____

Skin

- Bleeding tendency
- Skin cancer

____

Psychiatric conditions

- Drug addiction

____

Musculoskeletal

- Fractures
- Amputation
- Arthritis

____

Neurological

Paralysis

Transient ischemic attacks

Stroke

Fibromyalgia

____

Cardiovascular

Irregular heart beat

Heart attack

High blood pressure

Blood clots

____

Date of Last EKG

________ Month ________ Day ________ Year

Family History

Has anyone in your family had any of the following conditions?

Heart Disease

Yes

No

Stroke

Yes

No

Cancer

Yes

No

Bleeding Disorder

Yes

No

High Blood Pressure

Yes

No

Are you under the care of a pain management physician?

Yes

No

I, the undersigned, certify that the above medical history is complete to the best of my knowledge.

Signature

____

Date

__________ __________ ____________
Month Day Year