MDWest ONE, PC

Adult Medical History
(15 and older)

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 ______________________

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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

☐ Cigarettes ☐ Cigars ☐ e-Cigarettes/Vape Pen ☐ Chewing Tobacco ☐ Nicotine Gum ☐ Other: ____________

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