MDWest One, PC

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:
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___

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 _____

Social History

Occupation Current: _____ Disabled Reason for Disability: _____

Past: _____ Retired _____

MDWest One, PC

Do you currently live alone? No Yes - Relationship: _____

Have you ever been a smoker? No Yes - _____ Packs / Day Quit: _____ Months Ago _____ Years ago

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** _____