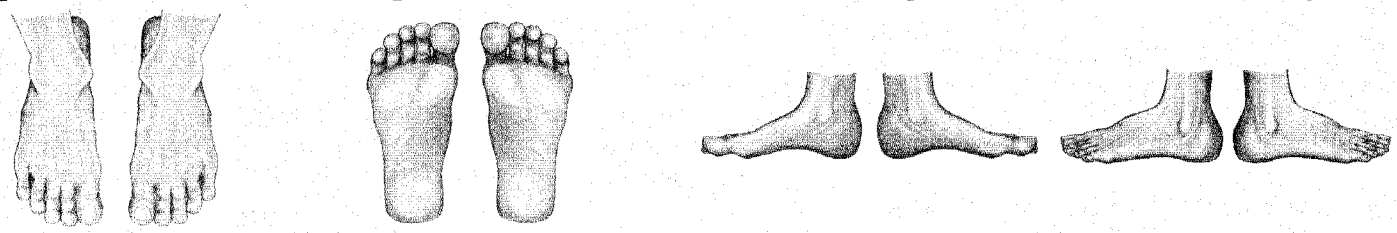
# Medical History

Patient Name: _____

**Reason For Today's Visit:**
Pain Swelling Numbness Ingrown Nail Wart Corn/Callus Other _____

**Please mark with an X the area of concern:**

Right Left Right Left Left Right Left Right



How long have you had this condition?_____

Symptoms are: Improving Worsening Unchanged

Describe your pain:(Circle all that apply) Sharp Dull Aching Burning Tingling Other_____

Symptoms are worse when: Standing Walking Sitting Sleeping Other _____

Symptoms are worse: Morning Night All day

Previous treatments include: Rest Elevation Ice/Heat Over-the-counter inserts
Injections Brace/Bandage Surgery Medication_____

Have you been treated by another physician for the conditions: NO YES
Name of Doctor _____When_____

Are you receiving: Home Health/Aide____ Hospice ____In Nursing Facility____ Physical Therapy _____ None _____

**Allergies: (Circle all that apply)** None
Adhesive Tape Aspirin Codeine Novocaine Sulfa Drugs Penicillin Other _____

**Do you have a Pain Management Doctor: No Yes Dr:**_____
**Medications: Are additional medications listed on the back of the Financial Sheet? Yes No**
Name of Medicine Dosage What is it taken for?

_____

_____

_____

**Have you ever been treated for the following: (Please circle all that apply)**
Acid/Gastric Reflux Arthritis, degenerative / Arthritis, rheumatoid Asthma Back Problems Blood Clots
Diabetes Insulin / Noninsulin Eczema / Psoriasis Epilepsy Fibromyalgia Glaucoma Gout Heart Murmur
Hepatitis: type A B C D High Blood Pressure High Cholesterol Heart Condition (Coronary Artery Disease)
Kidney Problems Liver Involvement MRSA Phlebitis Rheumatic Fever Skin conditions

Stroke (CVA) Tuberculosis (type____) Cancer (type_____)

Have you ever been exposed to the AIDS virus: YES NO

Do you wear glasses / contacts? YES NO
**Family Medical History:** Gout: Mother /Father Diabetes: Mother/Father High Blood Pressure: Mother/Father
Rheumatoid Arthritis: Mother/Father Fibromyalgia: Mother/Father

**Previous Surgeries/Hospitalizations:**
Hysterectomy: Date_____ Tubal Ligation: Date _____
Joint Replacement: Location _____ When_____
Other _____

**Social History:** Height Weight Shoe size
Are you pregnant or a chance you could be pregnant? Yes No Due Date:_____
Do you smoke: Yes No Quit Packs/day: How many years:
Do you drink alcohol: Yes No How much? Claustrophobic: Yes No
Do you use recreational drugs? Yes No Pacemaker or Defibulator: Yes No