Medical History Form - Dr. Delgado

Staff use	BP:
	HR:

Name: _____ **Age:** _____ **Date:** _____

Height: _____ **Weight:** _____ **DOB:** _____ **Primary Physician:** _____

Are you: ❑ Right Handed ❑ Left Handed **PHARMACY (Name, address):** _____

What is the reason for this visit? _____

What body part is involved? (Please mark in the table below)

Shoulder	Elbow	Wrist	Hand	Hip	Knee	Ankle	Foot	Neck	Back
☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L

Was your problem caused by an injury? ❑**YES** ❑**NO**

☐ **NO Injury:** Onset was ❑Gradual or ❑Started all of a sudden

☐ **YES Injury:** ☐Fall ☐Sport ☐Hit by car ☐Motorcycle accident ☐Car accident ☐Work accident ☐Other_____

Date of injury:_____*Please specify how it happened below.*

Comments; describe how problem started or how injury occurred (i.e. fell from a standing height, twisted ankle, head-on car accident etc.):

_____

How long has the pain been present?___Day(s)___Week(s) ___Month(s) ____Year(s) *OR* **Start date**? _____

On a scale of 0-10 (10 being the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? ❑ sharp ❑ dull ❑ stabbing ❑ throbbing ❑ aching ❑ burning

The pain is: ❑ constant ❑ comes and goes (intermittent)

Symptoms occur during: ❑rest ❑joint motion ❑minimal activity ❑exercise ❑walking ❑weight bearing ❑randomly

Do you have: ❑ swelling ❑ bruises ❑ numbness ❑ tingling ❑ weakness ❑ locking/catching ❑ giving way ❑ fevers/chills ❑ abrasions/lacerations/wounds ❑ gait difficulty (unsteady on feet)

Since the problem started, it is getting: ❑ better ❑ worse ❑ unchanged

What makes your symptoms <u>WORSE</u>? ❑ standing ❑ walking ❑ lifting ❑ exercise ❑ twisting ❑ lying on the side ❑ bending ❑ squatting ❑ kneeling ❑ stairs ❑ sitting ❑ joint motion ❑ weight bearing

What makes your symptoms <u>BETTER</u>? ❑ rest ❑ elevation ❑ ice ❑ heat ❑ medication ❑ Other:

Have you had any of these <u>TREATMENTS</u>? INJECTION ❑ Y ❑ N BRACE ❑ Y ❑ N PHYSICAL THERAPY ❑ Y ❑ N CANE/CRUTCH ❑ Y ❑ N ANTI-INFLAMMATORY MEDICATION ❑ Y ❑ N NARCOTIC MEDICATION ❑ Y ❑ N

Did they help? ❑**YES** ❑**NO**

Does your condition prevent you from: ❑ walking ❑ running ❑ gardening ❑ exercising ❑ hiking ❑ lying on the side ❑ sport activities ❑ working ❑ Other: _____

What <u>TESTS/SCANS</u> have you had for this problem? ❑ X-rays ❑ MRI ❑ CT Scan ❑Bone Scan ❑ Nerve Test (EMG/NCV)

Where? _____

Have you already had surgery or been seen by another physician for the above problem? ❑ Y ❑ N Please describe:

_____

_____

Medical History: Check all that apply ❑ None

Musculoskeletal:

- ❑ Cerebral Palsy
- ❑ Fibromyalgia
- ❑ Gout
- ❑ Rheumatoid arthritis
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Other:

Cardiovascular:

- ❑ Heart attack
- ❑ CHF
- ❑ High cholesterol
- ❑ High blood pressure
- ❑ Arrhythmia
- ❑ Other:

Gastrointestinal:

- ❑ Ulcer
- ❑ Colitis
- ❑ Hepatitis
- ❑ GI Bleed
- ❑ Crohn's/UC
- ❑ Other:

Neurological:

- ❑ Seizures
- ❑ Stroke/TIA
- ❑ Parkinson's
- ❑ Alzheimer's
- ❑ Other:

Vascular/Blood:

- ❑ Anemia
- ❑ Aneurysm
- ❑ DVT/PE (blood clot in leg/lungs)
- ❑ Sickle Cell Dz
- ❑ Peripheral arterial disease/claudication
- ❑ Other:

Pulmonary

- ❑ Asthma
- ❑ COPD/emphysema
- ❑ Sleep apnea
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Other:

Kidney:

- ❑ Kidney stones
- ❑ Kidney failure
- ❑ Dialysis
- ❑ Other:

Infectious:

- ❑ HIV
- ❑ Hep A/B/C
- ❑ Other:

Other Problems:

- ❑ Diabetes
- ❑ Thyroid problems
- ❑ Cancer
- ❑ Urologic
- ❑ Gynecologic
- ❑ Orthopedic fractures
- ❑ Anesthesia problems
- ❑ Skin
- ❑ Mental Illness
- ❑ Substance abuse history
- ❑ Alcohol abuse history
- ❑ Other

Please list any other hospitalizations / illnesses / injuries: _____

Surgical Procedures: Previous surgeries — List procedures, surgeon, and date ❑NONE

Operation	Date

Problems with anesthesia? ❑ No ❑Yes → If yes, explain:

Social History:

1. **Do you use tobacco? ❑Y** (packs per day___ for ____ years) **❑N** **❑Former smoker** (ppd____ , quit in_____)
2. Alcohol use: ❑ Never ❑ Occasional ❑ Frequently/every day → drinks per day_____
3. Marital status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Partner/Significant Other
4. Education: ❑GED ❑High School ❑Associates ❑Bachelors ❑Masters ❑Other: _____
5. Substance abuse (prescription or illicit): ❑Never ❑Currently ❑In the past ❑Recovering addict
6. Occupation: _____

Family History ❑ NONE

Please list all diseases/conditions that run in your family (i.e., diabetes, heart disease, DVT/PE, Kidney disease, cancer, arthritis, bleeding disorders, anesthetic problems, etc.):

Mother is ❑alive ❑deceased If deceased, died of _____ Age: _____

Father is ❑alive ❑deceased If deceased, died of _____ Age: _____

ALLERGIES to medications/ dye / food / latex / metal ❑None ❑No known drug allergy

Allergy	Reaction (rash, hives, throat swelling, wheezing, shock, nausea/vomit, upset stomach)

MEDICATIONS and dose taken: ❑Not taking any medication

Medication	Dose	How often taken

Review of Systems (check all that apply) ❑None

General:
- ◊ Fever/chills
- ◊ Weight loss or gain
- ◊ Fatigue

Eyes:
- ◊ Glasses/contacts
- ◊ Blurring vision
- ◊ Changes in vision

Ears, nose, mouth, throat:
- ◊ Hearing loss
- ◊ Congestion
- ◊ Nose bleeds
- ◊ Sore throat
- ◊ Mouth/throat ulcers
- ◊ Tooth problems

Gastrointestinal:
- ◊ Heart burn
- ◊ Vomiting
- ◊ Diarrhea
- ◊ Constipation

Respiratory:
- ◊ Cough
- ◊ Shortness of breath
- ◊ Snoring
- ◊ Wheezing

Cardiovascular:
- ◊ Chestpain
- ◊ Palpitations
- ◊ Leg swelling

Hematology, lymphatic:
- ◊ Easy bruising
- ◊ Easy bleeding
- ◊ Anemia (low blood count)
- ◊ Enlarged lymph nodes

Musculoskeletal:
- ◊ Joint pain
- ◊ Stiffness
- ◊ Extremity pain
- ◊ Instability

Neurologic:
- ◊ Fainting / dizziness
- ◊ Weakness
- ◊ Numbness or tingling sensation

Endocrine:
- ◊ Diabetes
- ◊ Excessive thirst or urination
- ◊ Heat or cold intolerance

Psychiatric:
- ◊ Depression / Anxiety
- ◊ Nervousness
- ◊ Hallucinations

Allergic:
- ☐ Metal sensitivity
- ☐ Reaction to foods/environment

Skin, hair, nails:
- ◊ Abrasion / Laceration / Wound
- ◊ Rash or skin eruptions
- ◊ Poor wound healing
- ◊ Redness

Genitourinary:
- ◊ Difficult / Painful urination
- ◊ Blood in urine
- ◊ Frequent ur

Patient Signature: Date: Physician Signature: