PREMIER *medical group*

MEDICAL HISTORY

Patient Name:_____ Date of Birth:_____
Today's Date:_____

Please list the problem(s) that brings you in today:_____
_____
_____

Onset: Gradual_____ Sudden_____ Duration: _____Days _____Weeks _____Months _____Years
Injury:_____ Type of pain:_____
Previous Treatment:_____
Surgical History:_____
☐ Tonsils_____ ☐ Gallbladder_____ ☐ Gastric_____
☐ Appendix_____ ☐ Foot_____ ☐ Rectal_____
☐ Hernia_____ ☐ Female_____ ☐ Injuries/Fractures_____

Pain: On_____ Off_____ Weight-bearing Footgear:_____
Please mark any of the following medical conditions that you have ever had:
☐ Diabetes_____ ☐ Ulcers_____ ☐ Rheumatic Fever_____
☐ Cardiac_____ ☐ Cancer_____ ☐ Phlebitis_____
☐ Hypertension_____ ☐ TB_____ ☐ Bleeding Disorders_____
☐ Arthritis_____ ☐ Stroke_____ ☐ HIV/AIDS_____
☐ Epilepsy_____ ☐ Asthma_____
☐ Gout_____ ☐ Kidney_____
☐ Nervous Disorders_____ ☐ Liver_____
☐ Other_____
_____
List any medications you are taking on a regular basis or now:_____
_____
_____

Are you allergic to any of the following:
☐ Penicillin_____ ☐ Aspirin_____ ☐ Codeine_____
☐ Local Anesthetics_____ ☐ Iodine_____ ☐ Tape/latex_____
Allergic to any food or environmental sources:_____

List any blood relatives with the following conditions:
☐ Diabetes_____ ☐ Foot_____
☐ Gout_____ ☐ Other_____

Do you smoke? Yes____ No____ If yes, how long? _____
Do you drink alcohol? No___ Occasionally____ Regularly____
Do you have history of previous drug abuse? Yes____ No____
Are there any cultural beliefs that might affect the care you receive in our office today? Yes____ No____
Do you require interpreter services? Yes____ No____