TEXAS SPECIALIST CENTER
PROFESSIONAL ASSOCIATES

MEDICAL HISTORY FORM

Patient Name: _____ **Date of Birth:** _____
Age: _____ **Sex:** ○ M ○ F **Height:** _____ **Weight:** _____
Race: _____ **Ethnicity:** _____ **Preferred Language:** _____
Referring Physicians Name: _____
Part of the body being seen for today: ○ R ○ L _____

In this section, check the box which best describes how your problem started. Please answer the questions related to the box you checked.

○ **NO INJURY** Was the onset ○ Gradual ○ Sudden Onset Date: _____ ○ **INJURY** ○ Accident ○ Sport Date: _____ ○ **INJURY AT WORK** Date: _____ ○ Lift ○ Twist ○ Fall ○ Bend ○ Pull ○ Reach ○ Repetitive ○ **AUTO ACCIDENT** Date: _____	**Description of Injury / Accident** _____ _____ _____ _____ _____ _____

Have you had a problem like this before? ○ N ○ Y

Were you seen in the E.R. for this problem? ○ N ○ Y Which E.R.? _____
What test scans have you had for this problem?
○ X-rays ○ MRI ○ CAT Scan ○ Bone Scan ○ Nerve Test (EMG / NCV)
On a scale of 0-10 (10 is the worst) how severe is your pain? ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10
What is the quality of pain? ○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning

The pain is ○ Constant ○ Intermittent (comes & goes) Does the pain wake you from your sleep? ○ N ○ Y
I experience: ○ Swelling ○ Bruising ○ Numbness ○ Tingling ○ Weakness ○ Loss of control of bowel or bladder
○ Locking / Catching ○ Giving way ○ Pain ○ Stiffness Other _____

Since my problem started, it is: ○ Getting Better ○ Getting worse ○ Unchanged

What makes your symptoms worse: ○ Standing ○ Walking ○ Lifting ○ Twisting ○ Bending ○ Stairs ○ Exercise
○ Squatting ○ Kneeling ○ Sitting ○ Coughing ○ Sneezing ○ Bending ○ Lying in bed

What makes your symptoms better?: ○ Rest ○ Elevation ○ Ice ○ Heat Other:_____

PAST MEDICAL HISTORY

List all previous hospitalizations : ○ **None** **YEAR**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Are you taking, or have you ever taken, blood thinners? ○ N ○ Y If Yes, which one? _____

List any medications you are taking on a regular basis (including hormonal replacement therapy or birth control):

○ **None**

Medication	**Medication**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Name: _____

PAST MEDICAL HISTORY

Are you allergic to any medications? ○ N ○ Y If Yes, please list below:

Medication	**Reaction**
_____	_____
_____	_____
_____	_____

Other Allergies? ○ N ○ Y If Yes, what are they? _____ **Latex allergy?** ○ N ○ Y

Do you have a personal history or any of the following? ○ **NONE**

○ Excessive or Prolonged Bleeding	○ Rheumatic Fever	○ HIV / AIDS	○ Stroke
○ Blood Clots	○ Diabetes Type: _____		○ Circulatory Problems
○ Asthma	○ Reaction to Anesthesia Type: _____		○ Heart Disease / Defect
○ Stomach Ulcers	○ Cancer Type: _____		○ Chemotherapy / Radiation
○ Birth Defects	○ Arthritis Type: _____		○ Continuous Seizures
○ Problems with Wounds Healing	○ Hepatitis	○ Fractures / Joint Dislocations	○ Epilepsy
○ Emphysema	○ Bone or Joint Infections	○ Tuberculosis	○ Lung Disease
Are you Pregnant? ○ N ○ Y	○ Abnormal Blood Pressure	○ Chemical Dependency	○ Psychiatric Care
Claustrophobic? ○ N ○ Y	○ Pacemaker	○ Sleep Apnea	Use a C PAP? ○ N ○ Y

REVIEW OF SYSTEMS

HAVE YOU HAD PROBLEMS IN THE PAST 6 MONTHS?					**NONE**	**COMMENTS**
1) GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool		○	_____
2) ENDO	○ Thyroid Disease	○ Heat or Cold Intolerance			○	_____
3) CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue		○	_____
4) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss		○	_____
5) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing		○	_____
6) CV	○ Chest Pain	○ Palpitations			○	_____
7) RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath		○	_____
8) GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems		○	_____
9) SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps	○ Psoriasis	○	_____
10) NEU	○ Headaches	○ Dizziness	○ Seizures	○ Numbness	○	_____
11) PSY	○ Depression / Anxiety	○ Drug / Alcohol Addiction	○ Sleep Disorder		○	_____
12) HEM	○ Easy Bleeding	○ Easy Bruising	○ Anemia		○	_____

FAMILY HISTORY

HAVE ANY DIRECT RELATIVES HAD ANY OF THE FOLLOWING DISORDERS?

FATHER:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Bleeding Problems	○ Rheumatoid Arthritis
MOTHER:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Bleeding Problems	○ Rheumatoid Arthritis
SIBLING:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Bleeding Problems	○ Rheumatoid Arthritis

SOCIAL HISTORY

Do you use tobacco? ○ N ○ Y If Yes, packs per day _____ ○ Quit **Informed of Smoking Risk?** ○ N ○ Y
Alcohol use? ○ N ○ Y ○ Quit If yes, How much? _____ How often? _____
Marital History: ○ Married ○ Single ○ Divorced ○ Widowed
Are you currently working? ○ Y ○ N ○ Retired ○ Disabled If no, when did you last work? _____
Are you currently on any work restrictions? ○ N ○ Y If Yes, what are they? _____
Occupation: _____ **Employer:** _____ ○ **Student**

_____ _____
Signature **Date**