

**MEDICAL INFORMATION SHEET**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

Present Complaint: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN'S NAME** \_\_\_\_\_

**PHONE** \_\_\_\_\_

**Please check any treatment that you have had for the current complaint:**

MRI     CTSCAN     THERAPY     XRAYs     SURGERY     OTHER

When did this injury occur: \_\_\_\_\_

How did this injury occur: \_\_\_\_\_

Was it related to a motor vehicle or work related injury \_\_\_\_\_

**Past Medical History – Please check all that apply:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Blood Clots          | <input type="checkbox"/> Osteoporosis                |
| <input type="checkbox"/> Recurrent Infections | <input type="checkbox"/> Ulcers               | <input type="checkbox"/> Gout                        |
| <input type="checkbox"/> Bleeding Disorder    | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Thyroid Disease             |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> High Cholesterol            |
| <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> HIV/Aids                    |
| <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Other Communicable diseases |
| <input type="checkbox"/> Other _____          |   |  |

**Do you have any allergies?**

- Antibiotics/Mediations \_\_\_\_\_
- Surgical Tape
- Iodine/Shellfish
- Local or general Anesthesia
- Seasonal allergies
- Other \_\_\_\_\_

**CURRENT MEDICATIONS:** \_\_\_\_\_

\_\_\_\_\_

**PAST SURGICAL HISTORY** \_\_\_\_\_

**Who referred you to our practice?**

- Patient     Primary Care Physician     Another Physician     Insurance Plan     Online Directory

**Patient's Signature** \_\_\_\_\_