

Patient Medical History Form

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PATIENT NAME: _____

DATE OF BIRTH: _____

Please answer the following questions.

1. **What hand do you use the most?** (Please circle one) RIGHT LEFT

2. **Do you have any allergies to medications?** NO YES

Please list and describe the type of reaction (e.g. rash, couldn't breath, etc.):

3. **Do you have any allergies/sensitivities to dusts, chemicals, or other substances?** NO YES

Please list:

4. **Are you presently taking any medications (prescribed or over-the-counter)?** NO YES

Please list the names, dosages, and how often you take them (include herbal products):

5. **Have you ever had a tetanus (lockjaw) immunization/boosters?** NO YES NOT SURE

Approximate year of last booster: _____ or _____

- less than 5 years ago
- between 5-10 years ago
- more than 10 years ago/don't remember

6. **Have you ever had any surgeries or significant hospitalizations?** NO YES

Please list:

If any of these were work-related, please place a \surd in front of the procedure(s)

7. **Family History: Does anyone in your family have or had any of the following:**

	<i>Yes</i>	<i>No</i>	<i>Whom?</i>
Heart disease/high blood pressure/strokes?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes/ sugar problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer? (<i>What types?</i>)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	_____

	<i>Alive</i>	<i>Age(s)</i>	<i>Dead</i>	<i>(If no longer alive, what did they die from and at what age?)</i>
Father	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Brother(s)	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Sisters(s)	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Children	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____

8. **Has it ever been necessary for you to change your type of work or job site due to health conditions or injuries? Do you have any permanent disabilities from a work or military injury?** NO YES

Please describe: _____

9. **Have you ever experienced heat-related problems?** NO YES

Please describe (e.g. faints, exhaustion, dehydration, etc.): _____

10. **Do you currently smoke?** NO YES  # Packs per day? _____
 If you used to smoke, when did you quit? 19_____ How many years total? _____

Do you currently, or have you ever chewed tobacco? NO YES

11. **Do you drink alcohol?** NO YES beer hard liquor wine

of drinks per day: _____
 Have you ever felt a need or been told you should cut down on your drinking? NO YES
 Have people annoyed you by criticizing your drinking? NO YES
 Have you ever felt bad or guilty about your drinking? NO YES
 Have you ever had an eye-opener in the morning? NO YES

12. **Do you currently, or have you ever had a substance (drug) dependency problem?** NO YES

Please describe: _____

 Have you gone through a rehabilitation program? NO YES

13. **Do you work any other jobs, or participate in any sports/recreational activities?** NO YES

Please describe: _____

14. **Have you ever had, or have you now, any of the following?**

	YES	NO		YES	NO
Frequent headaches			Diabetes or thyroid problems		
Head injury e.g. concussions			Cancer		
Seizures/convulsions			Broken bones or sprains		
Faints/blackout spells			Arthritis (swollen, painful joints)		
Eye injuries/problems			Shoulder problems		
Hearing problems, ringing ears			Tendinitis of hand/wrist/forearm		
Sinus problems			Carpal tunnel syndrome		
Asthma/difficulty breathing			Knee problems		
High blood pressure			Ankle/foot problems		
Heart trouble/ strokes			Serious infections/sexually transmitted dz		
Ulcers or heartburn problems			Hernias		
Hepatitis (A, B, C, or other), H.I.V.			Depression/anxiety/high stress		
Abdominal pain			Big swings in weight		
Genitourinary tract problems			Anything not included in this form		

WOMEN: Have you ever been pregnant? No Yes (How many times? _____ How many children do you have? _____)

Briefly describe any "YES" answers: _____

FOR PHYSICIAN USE ONLY

I have reviewed the above information.

 Physician's Signature Date