# MORGAN KALMAN CLINIC

## PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Age _____ Today's Date _____

Occupation: _____ Employer: _____

Referring Physician: _____ Primary Care Physician: _____

Height: _____ Weight: _____

Is the injury work related or the result of an accident? **Explain**.

Please describe your primary complaint and duration of your symptoms:

What activities, movements or positions make your symptoms **worse**?

What activities, movements or positions make your symptoms **better**?

What activities are difficult or limited because of your condition?

What treatments have you had for this condition, such as surgery, injections, therapy, etc?

Have you been seen by other physicians for this condition? **Who and when**?

Was imaging completed such as X-Rays, MRI, CT Scan or bone scan performed for these symptoms? If so, **where and when**?

Were you treated in an Emergency Room / Hospital / Medical Aid Unit for this problem? If so, **where and when**?

## Page 2 - Patient Medical History

Past Medical History: List active or past medical problems such as diabetes, heart attack, high blood pressure, etc.

_____ _____

_____ _____

_____ _____

List previous surgeries:

_____ _____

_____ _____

_____ _____

List medications and dosages, include nutritional supplements:

| Medication | Dosage | Medication | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Drug allergies and type of reaction: _____

Any other allergies (such as Latex)? ❑ Yes ❑ No Describe: _____

Do you currently smoke? ❑ Yes ❑ No How much per day _____

Did you ever smoke? ❑ Yes ❑ No When _____ Date you quit? _____

Do you drink alcohol? ❑ Yes ❑ No How often? _____

Do you have a history of drug or alcohol addiction? ❑ Yes ❑ No Have you or are you in rehab? ❑ Yes ❑ No

Do you have a pain management physician? ❑ Yes ❑ No If yes,

Name: _____ Phone #: _____

When was your last physical examination? Date: _____ Physician: _____

Was an EKG performed: Date: _____ Where: _____

Any lab work peformed: Date: _____ Where: _____

If applicable: Last Menstrual Cycle: _____

Are you pregnant? ❑ Yes ❑ No Due Date: _____

OB/GYN Name: _____

## Page 3 - Patient Medical History

FAMILY HISTORY: If any of the following have been diagnosed in your immediate family check appropriately.

- ❑ Allergies
- ❑ Fibromyalgia
- ❑ Rheumatoid or Osteoarthritis
- ❑ Heart Disease
- ❑ Tuberculosis
- ❑ High Cholesterol
- ❑ Hypertension
- ❑ Cancer
- ❑ Diabetes
- ❑ Strokes

PERSONAL HISTORY

**Heart - Cardiovascular**

- ❑ Heart Attack
- ❑ Hypertension
- ❑ Skipping/Irregular heartbeat
- ❑ Difficulty breathing
- ❑ Chest Pains with exercise or effort
- ❑ Ankle swelling or puffiness
- ❑ Deep Vein Thrombosis (blood clot) **Where?** _____

**Head - Neck**

- ❑ Frequent headaches
- ❑ Blurred vision not corrected with eye glasses
- ❑ Ringing in ears
- ❑ Frequent nosebleeds
- ❑ Loss of vision - **Please give details:** _____
- ❑ Dental issues - **Please give details:** _____
- ❑ Hearing loss - **Please give details:** _____

**Pulmonary - Lungs**

- ❑ Chronic coughing
- ❑ Spit up blood
- ❑ Frequent upper respiratory infections
- ❑ Night sweats
- ❑ Asthma
- ❑ Wheezing - **Please give details:** _____

**Stomach - Intestines**

- ❑ Clay or black tarry stools
- ❑ Chronic diarrhea
- ❑ Hemorrhoids
- ❑ Appetite loss - **Please give details:** _____
- ❑ Rectal bleeding - **How long?** _____
- ❑ Vomit blood - **How long?** _____

**Muscles - Joint**

- ❑ Physically handicapped
- ❑ Joint muscle pain
- ❑ Seizures
- ❑ Numbness in limbs
- ❑ Disturbance with gait (walking smoothly)
- ❑ Paralysis
- ❑ Stroke
- ❑ Trouble getting in or out of bed

**Neuropsychological**

- ❑ Depression
- ❑ Memory loss
- ❑ Anxiety
- ❑ Claustrophobia
- ❑ Mental illness
- ❑ Paralysis / Weakness
- ❑ Alcohol abuse
- ❑ Illegal drug use

**Infectious Diseases**

- ❑ HIV
- ❑ Hepatitis
- ❑ MRSA

## Page 4 - Patient Medical History

In the event you would request a refill called into your pharmacy, please provide the following information:

Pharmacy Name: _____

Location: _____

Phone Number: _____

Please share with us any other specialist you are currently treating with:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

THANK YOU FOR YOUR PATIENCE AND COOPERATION IN FILLING OUT THIS FORM.

*As a patient of Morgan Kalman Clinic, I verify that all of the above information is true and accurate to the best of my knowledge. Should any of the above information change I understand that it is my responsibility to notify the practice in writing as to those changes.*

PATIENT / GUARDIAN SIGNATURE: _____

DATE SIGNED: _____

PHYSICIAN SIGNATURE: _____

DATE SIGNED: _____