

# Medical History

CSOS Doctor: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Patient's Legal Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
 Email Address \_\_\_\_\_ Occupation \_\_\_\_\_  
 Birthday \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Date of Injury / Onset of Illness: \_\_\_\_\_ Is this a work related injury? Yes No

Date Stopped Work (if applicable): \_\_\_\_\_ If work related, name of employer when injured: \_\_\_\_\_

Date Returned to Work (if applicable): \_\_\_\_\_

Area of body injured / painful - include which side: \_\_\_\_\_ Right Left

How injury / illness happened: \_\_\_\_\_

Are you using a: Cane \_\_\_\_\_ Walker \_\_\_\_\_ Crutches \_\_\_\_\_ Braces \_\_\_\_\_ Wheelchair \_\_\_\_\_ Other \_\_\_\_\_

Cause of Death First Generation relatives: Parent \_\_\_\_\_ Sibling \_\_\_\_\_ Offspring \_\_\_\_\_

Please check if you or your family had/has any of the following:

Problem	Self	Family Member	Problem	Self	Family Member	Problem	Self	Family Member
Myocardial Infarction			Epilepsy / Seizures			Gout		
Heart attack			Nervous disorder			Cancer		
Coronary Artery Disease			Stroke			Depression		
Heart disease			Bladder / Kidney			Dizziness		
High Cholesterol			Gastrointestinal			Migraines		
Hypertension / High BP			Acid Reflux			Skin		
Anemia			Ulcers			Sleep apnea		
Bleeding tendencies			Hepatitis / Yellow jaundice					
HIV (AIDS)			Diabetes					
Blood clots			Neuropathy					
Asthma			Endocrine / Thyroid					
Emphysema			Glaucoma / Cataract					
			Arthritis					

Please list past illnesses or clarify above: \_\_\_\_\_

Are you allergic to any medications - drugs? Yes No If yes, please explain: \_\_\_\_\_

Are you allergic to: Iodine Adhesive Tape Plastic Bandages Merthiolate Latex Other: \_\_\_\_\_

\*Continue on back if needed

List all medications (include birth control, over the counter, and herbal medications you routinely take):

Medication/Amount	Dosage	Medication/Amount	Dosage
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____
		7. _____	_____
		8. _____	_____
		9. _____	_____

Please list all previous surgeries and dates:

Surgery	Date	Surgery	Date
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Vital Signs: Pulse \_\_\_\_\_ Resp. \_\_\_\_\_ BP \_\_\_\_\_ Temperature \_\_\_\_\_ BMI \_\_\_\_\_

Lives alone \_\_\_\_\_ Lives with \_\_\_\_\_ Are you pregnant? Yes No

Do you smoke or chew tobacco? Yes No How much a day? \_\_\_\_\_

Do you drink? Beer Wine Alcohol How much? \_\_\_\_\_ How often? \_\_\_\_\_

Past or present drug abuse? \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date Additional Reviews: \_\_\_\_\_