

PATIENT MEDICAL HISTORY FORM

DATE: _____

NAME: _____ DATE OF BIRTH: _____ AGE: _____

REFERRING PHYSICIAN: _____ FAMILY PHYSICIAN: _____

HISTORY OF PRESENT ILLNESS:

Please explain the current condition that you are being seen for: _____

When did your symptoms begin?: _____ Have the symptoms or pain changed?: better same worse

If pain was graded (10 being the most severe), how would you score your pain when the incident happened?: _____

Rate your pain now? _____

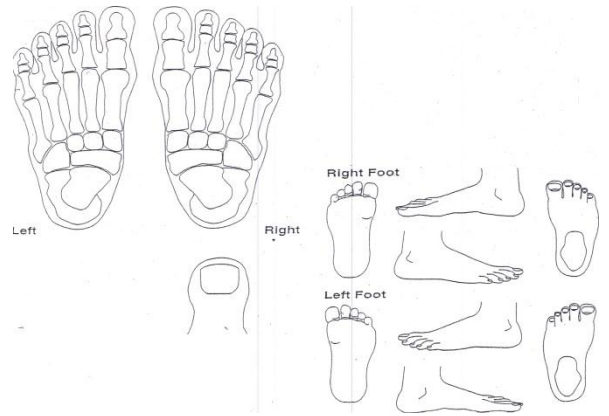
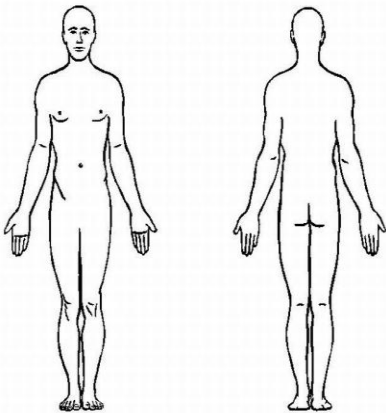
Does the problem interfere with your normal functions? If yes, please explain: _____

Do you experience pain while: walking sitting lifting bending lying flat sneezing or coughing

If this was an accident, how and when did it happen? _____

Have you had any previous treatment or surgery for this problem, please explain: _____

Please circle in the diagrams below where your pain is:



PRIOR MEDICAL HISTORY

Have you had any of the following medical problems?: (please circle Y or N and provide details below)

| | | | | | | | | |
|-------------------------|---|---|-----------------------------------|---|---|-------------------------|---|---|
| COPD | Y | N | Stomach Ulcers | Y | N | Cancer | Y | N |
| Asthma | Y | N | Liver Disease | Y | N | Seizure Disorder | Y | N |
| Tuberculosis (TB) | Y | N | Kidney Disease | Y | N | Epilepsy | Y | N |
| Lung Disease | Y | N | Bladder Condition | Y | N | CVA(Stroke) | Y | N |
| Coronary Artery Disease | Y | N | Thyroid Disease | Y | N | Psychological Condition | Y | N |
| Heart Disease | Y | N | High Cholesterol | Y | N | Osteoarthritis | Y | N |
| Heart Attack | Y | N | Diabetes – Type I or II | Y | N | Rheumatoid Arthritis | Y | N |
| Hypertension | Y | N | Gout/Pseudo Gout | Y | N | Scoliosis | Y | N |
| Reflux | Y | N | Ongoing Infection (HIV/Hepatitis) | Y | N | | | |

List any additional medical problems: _____

FAMILY MEDICAL HISTORY

Please list any serious illnesses or early deaths in your immediate family. What is their relation to you?

SOCIAL HISTORY

Do you smoke? Y N If yes, how many packs per day and for how long? _____/_____

Did you smoke previously? Y N If yes, how many packs per day, for how long and year quit? _____/_____/_____

Do you drink alcohol? Y N If yes, # of drinks/how often: _____/_____

Do you use illicit narcotics? Y N If so, what type?: _____

Do you have a history of drug abuse? Y N

How would you describe your lifestyle? (please circle): Sedentary Moderate Active

What is your current occupation?: _____ How long?: _____

Prior occupation?: _____ How long?: _____

Please list any heavy physical activities or repetitive duties your job requires: _____

REVIEW OF SYSTEMS

Do you now or have you had any chronic or recurring problems related to the following?: (Circle Y or N)

| | | | | | | | | |
|----------------------------------|---|---|--------------------------------|---|---|-----------------------------------|---|---|
| Constitutional: | | | Gastrointestinal (cont) | | | Neurologic (cont.) | | |
| Fever | Y | N | Difficult/Painful Swallowing | Y | N | Seizures/Epilepsy | Y | N |
| Weight Gain | Y | N | Hepatitis | Y | N | Tingling/Numbness | Y | N |
| Eyes: | | | Jaundice | Y | N | Tremors | Y | N |
| Visual Problems | Y | N | Genitourinary: | | | Musculoskeletal: | | |
| Head, Ears, Nose, Throat: | | | Bladder Infection | Y | N | Fibromyalgia | Y | N |
| Dizziness | Y | N | Enlarged Prostate | Y | N | Fractures | Y | N |
| Headaches | Y | N | Female Problems | Y | N | Joint Pain/Swelling | Y | N |
| Hearing Problems | Y | N | Urinary Frequency | Y | N | Musculoskeletal Pain | Y | N |
| Neck Pain | Y | N | Kidney Disease/Stones | Y | N | Systemic Arthritis | Y | N |
| Breasts: | | | Prostate Cancer | Y | N | Endocrine: | | |
| Lumps | Y | N | Urinary Incontinence | Y | N | Thyroid Disease | Y | N |
| Heart: | | | Urinary Strictures | Y | N | Psychiatric: | | |
| Chest Pain | Y | N | Skin: | | | Anxiety | Y | N |
| Irregular/Rapid Heart Beat | Y | N | MRSA Infection | Y | N | Depression | Y | N |
| Known Heart Problems | Y | N | Persistent Itching | Y | N | Blood and Gland Disorders: | | |
| Shortness of Breath | Y | N | Skin Infections | Y | N | Bleeding Disorders | Y | N |
| Respiratory: | | | Skin Rash/Lesions | Y | N | Blood Clotting Problems | Y | N |
| Chronic/Frequent Cough | Y | N | Neurologic: | | | Easy Bruising | Y | N |
| Lung Lesions/Tuberculosis | Y | N | Alzheimer's | Y | N | Swollen Glands | Y | N |
| Shortness of Breath | Y | N | Loss of Balance | Y | N | Allergic and Immunologic: | | |
| Wheezing/Asthma | Y | N | Muscular Weakness/Paralysis | Y | N | Allergic Dermatitis | Y | N |
| Gastrointestinal: | | | Nerve Pain (Arms/Leg) | Y | N | Immune Deficiency | Y | N |
| Acid Reflux | Y | N | Neuropathy | Y | N | Sinus Allergy Symptoms | Y | N |
| Changes in Bowel Habits | Y | N | Parkinson's | Y | N | | | |

Other problems not listed: _____

IF YOU ARE PREGNANT OR HAVE REASON TO BELIEVE YOU MAY BE, PLEASE NOTIFY THE X-RAY TECHNOLOGIST.

Patient Signature or Signature of Guardian: _____

Print Name: _____ Date: _____