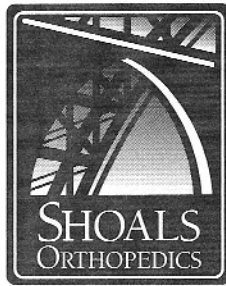


Phone: 256.718.4041
Fax: 256.718.3665



NEW PATIENT MEDICAL HISTORY

(Please ask for any assistance needed to complete this form.)

NAME: _____ DATE: _____

Age: _____ Race: _____ Marital Status: _____

Occupation: _____ Handedness: R / L

Primary Doctor: _____

Person Who Referred You (if applicable): _____

PAST SURGICAL HISTORY (PROCEDURE / YEAR):

_____	_____
_____	_____
_____	_____

PAST MEDICAL HISTORY: Y / N

Diabetes	Y or N	Blood Clots	Y or N	Other: _____
Heart Disease	Y or N	Bleeding Disorder	Y or N	_____
High Blood Pressure	Y or N	Thyroid Disease	Y or N	_____
Heart Attack	Y or N	Arthritis	Y or N	_____
Stroke	Y or N	Type: _____		_____
Stomach Ulcers	Y or N	Gout	Y or N	_____
Kidney Disease	Y or N	Cancer	Y or N	_____
Kidney Stones	Y or N	Nervous Disorder	Y or N	_____

** Additional Information As Needed: _____

REVIEW OF SYMPTOMS: Have you ever experienced any of the following? Circle all that apply.

Chest Pain	Palpitations/Heart Racing	Shortness of Breath
Unintentional Weight Loss	Excessive Fatigue	Change in Bowel or Bladder habits
Loss of Appetite	Difficulty Sleeping	

RECENT ILLNESS: _____

SERIOUS INJURIES: _____

MEDICATIONS: (Include over the counter, such as Aspirin & Tylenol®)

_____	_____	_____
_____	_____	_____

ALLERGIES: (Including tape/iodine/latex) and type of reaction.)

_____	_____	_____
_____	_____	_____

DO YOU SMOKE? Y or N HOW MANY PACKS PER DAY? _____

DO YOU CHEW TOBACCO? Y or N

DO YOU DRINK ALCOHOL? Never Occasionally Every Day

If yes, have you ever had alcohol withdrawal ("DT's")? Yes or No

HAVE YOU EVER USED IV DRUGS OR HAD A BLOOD TRANSFUSION PRIOR TO 1988? Yes or No

DO ANY IMMEDIATE BLOOD RELATIVES (parents, siblings, children) HAVE ANY OF THE FOLLOWING?

Circle all that apply.

Diabetes

High Blood Pressure

Cancer

Arthritis

Heart Disease

Bleeding Disorder

Stroke

Curvature of the Spine

WHY DID YOU COME TO THE DOCTOR TODAY? _____

IS THIS CONDITION RELATED TO YOUR JOB? Yes or No

If yes, did you report this to your employer? Yes or No

WHAT TREATMENT HAVE YOU RECEIVED, AND WAS IT HELPFUL?

Medicines: (list) _____

Injections - Y or N

Physical Therapy - Y or N

Time off from work or restricted duty? - Y or N

Surgery - Y or N

DO YOU HAVE ANY CONDITIONS THAT MAKE YOUR SYMPTOMS BETTER OR WORSE? PLEASE LIST.

OVER TIME, HAVE YOU GOTTEN Better Worse Stayed the Same

MD Notes: Reviewed By: _____ Patient Name: _____