MEDICAL HISTORY FORM
Dr. John Robinson

Name: _____

Your age: _____

Referring Doctor: _____

Primary Doctor: _____

Reason for today's visit: _____

_____

_____

Which side of the body?

☐ Left ☐ Right

Was this problem the result of an injury?

☐ Yes ☐ No

Date of injury: _____

If not an injury, how long have you had this problem?

_____

What else can you tell us about the problem?

_____

_____

_____

_____

HT_____ WT_____

Medical Problems: (examples: Diabetes, Asthma, High Blood Pressure, High Cholesterol, etc.)

_____

_____

_____

_____

_____

List ALL surgeries have you had in the past

Procedure	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List ALL prescription medications you take

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any medication allergies? ☐ YES ☐ NO

If yes, please list the medication and type of reaction:

_____

_____

Are you under the care of a Pain Management doctor?

Yes_____ No_____

MEDICAL HISTORY FORM
Dr. John Robinson

NAME_____

Marital Status: ☐ MARRIED ☐ SINGLE

☐ SEPARATED ☐ WIDOW ☐ WIDOWER

Hand Dominance: ☐ **Right** or ☐ **Left**

What is your occupation? _____

Do you use tobacco products? ☐ YES ☐ NO

If yes, what tobacco product? _____

For how many years? _____

Do you drink? Yes, or No
How often? Rarely, Occasionally, Socially, Daily

Family History: **Father**: Alive or Deceased
Mother: Alive or Deceased

Which family members have had any of the following?

Father: High Blood Pressure, Heart Disease, Diabetes, Cancer, Stroke

Mother: High Blood Pressure, Heart Disease, Diabetes, Cancer, Stroke

REVIEW OF SYSTEMS (Only circle those that apply)

GENERAL

Weight Change	YES	NO
Fever	YES	NO
Night Sweats	YES	NO
Loss of Appetite	YES	NO

NEUROLOGIC

Numbness or Tingling	YES	NO
Weakness	YES	NO
Seizures	YES	NO

EAR, EYE, NOSE, THROAT

Visual Changes	YES	NO
Hearing Changes	YES	NO
Hoarseness	YES	NO

GENITOURINARY

Burning Urination	YES	NO
Urinary Frequency	YES	NO
Incontinence	YES	NO

GASTROINTESTINAL

Heartburn	YES	NO
Constipation	YES	NO
Diarrhea	YES	NO
Blood in stool	YES	NO

SKIN

Rash	YES	NO
Sores	YES	NO
Easy Bruising	YES	NO

CARDIOVASCULAR

Chest pain	YES	NO
Dizziness or fainting	YES	NO
Palpitations	YES	NO

RESPIRATORY

Cough	YES	NO
Shortness of Breath	YES	NO
Wheezing	YES	NO

ALLERGY/IMMUNOLOGY

Food Allergies	YES	NO
Latex Allergies	YES	NO
Frequent Infections	YES	NO

PSYCHOLOGIC

Depression	YES	NO
Anxiety	YES	NO