Musculoskeletal Medicine & Pain Management Associates, P.C. DBA "Multicare"

Date :	Patient Name:	Date of Birth:

MEDICAL AND HEALTH HISTORY

Your personal health history is a vital part in visit with us today, please complete the following information.

MAIN PROBLEM
What is the reason for your visit today?
What happened RECENTLY to make you decide to seek help now?

Date of last physical exam: _____ Name of Provider: _____

Medical Conditions diagnosed by a doctor: _____

Surgeries: _____

Other hospitalizations: _____

SYMPTOMS - *Please mark if you have now*									
Fever	Yes		No		Difficulty starting/stopping stream	Yes		No	
Unexplained weight loss	Yes		No		Joint pain	Yes		No	
Chills	Yes		No		Black stools	Yes		No	
Changes in vision	Yes		No		Foot swelling	Yes		No	
Difficulty swallowing	Yes		No		Depression	Yes		No	
Problems with hearing	Yes		No		Anxiety	Yes		No	
Chest pain	Yes		No		Panic attacks	Yes		No	
Racing heart	Yes		No		Excessive thirst	Yes		No	
Palpitations	Yes		No		Frequent urination	Yes		No	
Cough	Yes		No		Swelling in the neck	Yes		No	
Wheezing	Yes		No		Swollen glands	Yes		No	
Shortness of breath	Yes		No		Easy bleeding	Yes		No	
Stomach pains	Yes		No		Poor healing	Yes		No	
Blood in stool	Yes		No		Frequent headaches	Yes		No	
Constipation	Yes		No		Loss of consciousness	Yes		No	
Blood in urine	Yes		No		Numbness in arms/legs	Yes		No	
Burning during urination	Yes		No		Worrisome or changing skin lesions	Yes		No	
Skin rashes	Yes		No		Hair loss	Yes		No	

CURRENT MEDICATIONS *(Include - all Prescriptions and over the counter including Vitamins)*

Name of Medication	Dose	Frequency
	Reaction	

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Allergies to medications	

Please use the back side of this paper if more room is needed. ***Continued on back YES___ No ___***

PERSONAL HISTORY - Do you have any history of the following conditions?					**If YES to any please Explain**
Thyroid Problems	Yes		No		
Seizures	Yes		No		
Stroke	Yes		No		
Asthma	Yes		No		
C.O.P.D.	Yes		No		
Sleep Apnea	Yes		No		
Coronary Artery Disease	Yes		No		
Congestive Heart Failure	Yes		No		
Chest Pain	Yes		No		
High Blood Pressure	Yes		No		
Elevated Cholesterol	Yes		No		
Heart Attack	Yes		No		
Implantable Devices	Yes		No		
Cardiac Arrhythmia	Yes		No		
Rheumatic Fever	Yes		No		
Diabetes	Yes		No		
Liver Problems	Yes		No		
Stomach Problems	Yes		No		
Irritable Bowel	Yes		No		
Syndrome	Yes		No		
Reflux (G.E.R.D.)	Yes		No		
Kidney Problems	Yes		No		
Incontinence of Urine	Yes		No		
Genitourinary Problems	Yes		No		
Osteoporosis	Yes		No		
Back or Neck Problems	Yes		No		
Arthritis	Yes		No		
Skin Problems	Yes		No		
Anemia	Yes		No		
Blood Disorder	Yes		No		
M.R.S.A. / V.R.E.	Yes		No		
Tuberculosis	Yes		No		
difficile	Yes		No		
Hepatitis	Yes		No		
HIV or AIDS	Yes		No		

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Depression	Yes		No		
Anxiety	Yes		No		
Eating Disorder	Yes		No		
Menstrual Problems	Yes		No		
Abnormal Pap Smear	Yes		No		
Cancer	Yes		No		
Drug or Alcohol Addiction	Yes		No		
Other Medical Problems	Yes		No		
SOCIAL HISTORY					
Do you feel safe at home	Yes		No		
Do you want to discuss abuse	Yes		No		
Is someone threatening you	Yes		No		
Do you smoke?	Yes		No		If Yes, how many per day?
Do you drink?	Yes		No		If Yes, how much?
Do you exercise regularly?	Yes		No		If Yes how often?
Are you pregnant?	Yes		No		**Are you Employed?** Yes No If So Where?
Is your Mother Deceased?	Yes		No		**Marital Status** Married Single Divorced Other
Is your Father Deceased?	Yes		No		**Highest Level of Education** College High School GED Other

FAMILY HISTORY *(If yes to any, please list relationship)* If Unknown Please check here

		Relationship				**Relationship**	
Aneurysms	Yes		No	Diabetes	Yes		No
Bleeding tendencies	Yes		No	Alcohol dependence	Yes		No
Breast cancer	Yes		No	Drug abuse	Yes		No
Colo-Rectal cancer	Yes		No	Heart problems	Yes		No
Ovarian cancer	Yes		No	Hypertension	Yes		No
Pancreatic cancer	Yes		No	Stroke	Yes		No
Other cancers	Yes		No	Mental illness	Yes		No

Please list any other questions or concerns you have:

I have answered the above questions to the best of my knowledge

Patient / Legal Guardian Signature *Date*