Medical History

CSOS Doctor: ______________________ Today's Date: ______________

Referring Doctor: ______________________

Patient's Legal Name: Last ______________ **First** ______________ **Middle** ______________

Email Address ______________________ **Occupation** ______________________

Birthday ____________ **Sex M F 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: ______________________

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

Please list past illnesses or clarify above: ______________________

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

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

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

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

Pharmacy Name: ______________________ Pharmacy Phone Number: ______________

Please list all previous surgeries and dates:

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

Vital Signs: Pulse ________ Resp. ________ BP ________ Temperature ________ BMI ________

I live: __ Alone __ with Spouse __ with Children __ with Parents __ in a Nursing Home with ______________

Do you smoke or chew tobacco? Daily / Occasionally / Previously / Never How much a day? ______________

Alcohol consumption? Yes No / Beer / Wine / Liquor How often? ____________ How much? ____________

Past or present drug abuse? ______________

If over 50 years old, have you had a flu vaccine this flu season? Yes No

If over 64 years old, have you ever had a pneumonia vaccine? Yes No

Females: If over 40 years old, have you had a mammogram in the past 2 years? Yes No Are you pregnant? Yes No

Signature of Patient: ______________________ **Date:** ______________

Signature of Physician: ______________________ **Date Additional Reviews:** ______ ______ ______ ______