John A. Saugy, Jr., M.D.

MEDICAL HISTORY FORM

NAME:_____ DATE:_____

Chief Complaint:_____ Date of Injury:_____

Past Medical History

(Check YES or NO for all)

Diabetes	☐ yes	☐ no
Hypertension	☐ yes	☐ no
Cancer	☐ yes	☐ no
(what kind) _____		
Stroke	☐ yes	☐ no
Heart Trouble	☐ yes	☐ no
Arthritis	☐ yes	☐ no
Seizures	☐ yes	☐ no
Bleeding Tendency	☐ yes	☐ no
Acute Infection	☐ yes	☐ no
Venereal Disease	☐ yes	☐ no
Hereditary Defects	☐ yes	☐ no
Blood Clots	☐ yes	☐ no
Gout	☐ yes	☐ no
Ulcer Disease	☐ yes	☐ no

Allergies to medicine: _____ ☐ none

What medications do you take: _____ ☐ none

_____

_____

Previous Surgeries (what kind, where, when?) _____ ☐ none

_____

_____

Previous Hospitalizations (for what, where, when?) _____ ☐ none

_____

Previous Fractures: (of what, when?) _____ ☐ none

_____

Review of Systems: (check if NONE / CIRCLE items)

	NONE	SYMPTOMS
Neurological		Headache fainting dizziness seizure numbness tingling weakness
Eyes / Ears / Nose		Vision change double vision pain hearing change ringing in ears smelling change nose bleeds congestion
Throat		Pain difficulty swallowing painful swallowing
Respiratory		Cough wheezing pain asthma short of breath blood in sputum
Cardiovascular		Chest pain palpitations irregular heartbeat swelling skin/color/tem change murmur
GI		Nausea vomiting blood in stool constipation diarrhea bleeding appetite change weight change pain
GU		Frequency hesitancy urgency blood in urine incontinence discharge pain painful urination
Musculoskeletal		Swelling range of motion change pain
Skin		Rash skin change pain itchiness
Psych / Substance Abuse		History of treatment:_____ ☐ Out-Patient ☐ In-Patient Over _____ months _____ years

Patient Social History:

What kind of work do you do: _____

Are you: ☐ right handed ☐ left handed

Marital Status ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Use of alcohol ☐ never ☐ rarely ☐ moderate ☐ daily ☐ recovering alcoholic

Use of tobacco ☐ never ☐ previously, but quit ☐ current pack/day

Use of drugs ☐ never ☐ type/frequency

Excessive exposure at home or work to ☐ fumes ☐ dust ☐ solvents ☐ noise

Family Medical History:	**Age**	**Diseases**	**if deceased, cause of death**
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____
Spouse	____	_____	_____
Children	____	_____	_____

Is there a family history of: ☐ diabetes ☐ cancer (what kind) _____ ☐ heart disease, other

Other inherited medical problem(s): _____

COMPLETED BY: _____

REVIEWED BY: _____

MD Signature