ADVANCED MUSCULOSKELETAL CENTERS, PA

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Medical History If yes, please explain

Do/did you have any heart problems? ☐ Yes ☐ No
____

Do/did you have any breathing/lung problems? ☐ Yes ☐ No
____

Do/did you have any kidney problems? ☐ Yes ☐ No
____

Do/did you have diabetes? ☐ Yes ☐ No
____

Do/did you have ulcers/gastritis? ☐ Yes ☐ No
____

Do/did you have any intestinal problems? ☐ Yes ☐ No
____

Do/did you have liver problems? ☐ Yes ☐ No
____

Do/did you have cancer? ☐ Yes ☐ No
____

Do/did you high blood pressure? ☐ Yes ☐ No
____

Do/did you have any other medical problems? ☐ Yes ☐ No
____

Surgical History

List any prior surgeries with dates ______________________________
____
____
____

Allergies

Allergy to Latex? ☐ Yes ☐ No

Allergy to Metal(s)? ☐ Yes ☐ No

Allergies to Medication? ☐ Yes ☐ No

If yes, please list: ______________________________

Medications

Please list names and dosage(s) of any medications you are now taking ______________________________
____
____

Social History

Do/did you smoke or chew tobacco? ☐ Yes ☐ No

Do/did you drink alcohol? ☐ Yes ☐ No

Are you currently working? ☐ Yes ☐ No ☐ Retired

FAMILY HISTORY: ☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ Alzheimer's ☐ Stroke
☐ Seizures/Epilepsy ☐ Blood Clots ☐ Osteoporosis ☐ Sudden Death
☐ Death before age 50 ☐ Rheumatoid Arthritis

Please Describe: ____

____

Review of Systems

1. Constitutional General ☐ None ☐ Recent weight changes ☐ Chills ☐ Fever ☐ Weakness / Fatigue
   ☐ Other ____
2. Eyes ☐ None ☐ Vision Change ☐ Glass / Contacts ☐ Cataracts ☐ Glaucoma
   ☐ Other ____
3. Ears, Nose, Throat ☐ None ☐ Loss of hearing ☐ Ear ache or infection ☐ Ringing in the ear ☐ Hoarseness
   ☐ Other ____
4. Cardiovascular ☐ None ☐ Chest Pain ☐ Swelling in legs ☐ Shortness of breath ☐ Palpitations
   ☐ Pacemaker
   ☐ Other ____
5. Respiratory ☐ None ☐ Shortness of Breath ☐ Wheezing / Asthma ☐ Frequent Cough
   ☐ Other ____
6. Gastrointestinal ☐ None ☐ Heartburn ☐ Acid Reflux ☐ Nausea or Vomiting ☐ Abdominal Pain
   ☐ Other ____
7. Musculoskeletal ☐ None ☐ Arthritis / Joint Stiffness ☐ Muscle Aches ☐ Swelling of joints
   ☐ Fractures / Dislocations
   ☐ Other ____
8. Skin ☐ None ☐ Rash ☐ Ulcers ☐ Abnormal Scars ☐ Sores ☐ Psoriasis
   ☐ Other ____
9. Neurologic ☐ None ☐ Headaches ☐ Fainting/blackouts ☐ Dizziness
   ☐ Numbness / tingling / loss of sensation
   ☐ Other ____
10. Psychiatric ☐ None ☐ Depression ☐ Nervousness ☐ Anxiety ☐ Mood Swings
    ☐ Other ____
11. Endocrine ☐ None ☐ Excessive thirst or hunger ☐ Hot/cold intolerance ☐ Hot Flashes
    ☐ Other ____
12. Hematologic ☐ None ☐ Easy Bruising ☐ Easy Bleeding ☐ Anemia
    ☐ Other ____

Signature ______________________________ Relation to Patient ______________________________

Date ______________________________