near ✱ site
work health solutions

DATE: ____________________

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

***** Preferred Pharmacy:**

ALLERGIES

❑ No Known Allergies ❑ Adhesive Tape ❑ Anesthesia ❑ Aspirin ❑ Codeine
❑ Dairy Products ❑ Iodine/Shellfish/Dye ❑ Latex ❑ Morphine ❑ Penicillin
❑ Sulfa Drugs ❑ Wheat ❑ Other_____________ ❑ Other_____________

Reaction:___________

FAMILY HISTORY – Please indicate if any of your immediate relatives had any of the following by placing an X in the appropriate box.

	MOTHER	**FATHER**	**SIBLING (Brother/Sister)**
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Occupation: ________________________________ ☐ Retired ☐ Disabled (reason ________________________)
☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic
☐**Yes** ☐**No -** Do you use tobacco?☐ Smoke (___ packs per day) ☐ Chew

SURGICAL HISTORY: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

MEDICAL HISTORY: Have you ever had any of the following?

❑ NONE of the problems listed
❑ allergies
❑ anemia
❑ arthritis conditions
❑ asthma
❑ arterial fibrillation
❑ bleeding problems
❑ BPH/Enlarged prostrate
❑ CAD/coronary artery disease
❑ cancer
❑ cardiac arrest
❑ celiac disease
❑ chest pain
❑ CHF congestive heart failure
❑ chronic fatigue syndrome
❑ depression
❑ diabetes
❑ drug/alcohol abuse
❑ erectile dysfunction
❑ fibromyalgia
❑ GERD/acid reflux
❑ heart disease
❑ high cholesterol
❑ hyperinsulinemia
❑ hyperlipidemia
❑ hypertension
❑ hypogonadism male
❑ hypothyroidism
❑ infection problems
❑ insomnia
❑ irritable bowel syndrome
❑ kidney problems
❑ menopause
❑ migraines/headaches
❑ neuropathy
❑ TBI/Concussion
❑ organ injury
❑ osteoporosis
❑ pulmonary embolism
❑ seizure disorders
❑ shortness of breath
❑ sinus conditions
❑ STDs
❑ skin disorder
❑ stroke
❑ tremors
❑ Other________________
❑ Other________________

MEDICATIONS: List any medications you are currently taking (please include over the counter medications).

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PERSCRIBING DOCTOR