

# NSS/Medical Profile

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE \_\_\_\_\_ Gender: M / F MR# \_\_\_\_\_ Date: \_\_\_\_\_

Current Symptoms: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Duration: \_\_\_\_\_

Area of Body to be Examined: •Left •Right \_\_\_\_\_ Currently working? •Yes •No •Disabled •Retired •Unemployed •Student

How did Accident/Injury Occur? \_\_\_\_\_ Date Last Worked: \_\_\_\_\_ Date Returned to Work \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Dominant Hand: L / R

## SOCIAL HISTORY

Marital Status S M D W P

No of Children \_\_\_\_\_

Do you Smoke? Yes No Type: \_\_\_\_\_

PPD \_\_\_\_\_ How Long \_\_\_\_\_ yrs

Have you ever smoked? Yes No

What year did you quit? \_\_\_\_\_

Do you drink alcohol? Yes No Drinks per week \_\_\_\_\_

Education Level:

Grade School Some High School High School Graduate

GED Some College Assoc Degree

Bachelors Masters Doctorate

Hobbies \_\_\_\_\_

## ALLERGIES TO MEDICATIONS

### Reaction

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## PAST SURGICAL HISTORY

### Year

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## FAMILY HISTORY

Father Age \_\_\_\_\_ / Age at death \_\_\_\_\_ Medical Problems \_\_\_\_\_

Mother Age \_\_\_\_\_ / Age at death \_\_\_\_\_ Medical Problems \_\_\_\_\_

List diseases that run in your family \_\_\_\_\_

Have you or anyone in your family had a severe reaction to anesthetics? Y / N / U

Have you or anyone in your family had a history of blood clotting problems? Y / N / U

Are you allergic to Latex? Y / N / U Are you allergic to Metal? Y / N / U

## CURRENT MEDICATIONS

### Dosage/Frequency

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## PAST MEDICAL HISTORY

### Year

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Please circle if you have been diagnosed with a history of the following by a physician:

Corrective lenses/contacts

Deafness

Ring in Ears

Irregular Heartbeat

High Blood Pressure

Heart Attack

Asthma

Bronchitis

COPD/Emphysema

Ulcers

Jaundice/Hepatitis

Liver Disease

Kidney Failure

Blood in urine

Venereal disease

Kidney Stones

Rashes/Scars/Masses

Fractures (Describe)

\_\_\_\_\_

Bleeding disorder

Blood Clots

Anemia

Phlebitis

Arthritis

Stroke

Epilepsy/Seizures

Incoordination

Blackouts

Headaches

Memory Loss

Depression

Anxiety

Schizophrenia

Thyroid Disease

Diabetes

Gout

Lupus

Rheumatoid Arthritis

Currently Pregnant? Y / N

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Ht \_\_\_\_\_ Wt \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_