

**Ted A. Jackson, M.D.**  
**Daniel J. Wood, M.D.**

**1306 KANAWHA BLVD., E., SUITE 100 • CHARLESTON, WV 25301-3001 • PHONE (304) 342-1113 • (800) 701-1113 • FAX (304) 346-2271**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
First Middle Initial Last

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Parent(s) and/or Guardian(s): \_\_\_\_\_

Referring Dr: \_\_\_\_\_ Family Dr.: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Have you seen another doctor for this? Who and when? \_\_\_\_\_

Injury related?  Yes  No Job related?  Yes  No Date of Injury: \_\_\_\_\_ Symptoms Onset: \_\_\_\_\_

**ALLERGIES**

Latex Allergies?  Yes  No Blood Test to Confirm?  Yes  No

Environmental?  Yes  No List: \_\_\_\_\_

Tape Allergies?  Yes  No List: \_\_\_\_\_

Drug Allergies?  Yes  No List: \_\_\_\_\_

Food Allergies?  Yes  No List: \_\_\_\_\_

List all drug allergies and type of reaction: \_\_\_\_\_

**MEDICATIONS** (Attach list if more than ten prescription medications)

Rx: \_\_\_\_\_ Rx: \_\_\_\_\_

Rx: \_\_\_\_\_ Rx: \_\_\_\_\_

Rx: \_\_\_\_\_ Rx: \_\_\_\_\_

Rx: \_\_\_\_\_ Rx: \_\_\_\_\_

Rx: \_\_\_\_\_ Rx: \_\_\_\_\_

Do you take insulin?  Yes  No Coumadin, Plavix, etc.?  Yes  No Home Oxygen?  Yes  No

(Daily) Aspirin?  Yes  No (Daily) Ibuprofen?  Yes  No Steroids?  Yes  No Vitamins?  Yes  No

Other OTC Supplements?  Yes  No List: \_\_\_\_\_

Any metal implants/devices?  Yes  No List: \_\_\_\_\_

For any prescription that this office would need to call in for you, what is the name, telephone number and address of your preferred pharmacy? \_\_\_\_\_

**MEDICAL HISTORY (PAGE 2)**

Name: \_\_\_\_\_  
First Middle Initial Last

Date: \_\_\_\_\_

**PERSONAL PAST MEDICAL HISTORY:**

Have you ever had:

- HIV?  Yes  No
- Abnormal bleeding?  Yes  No
- Asthma?  Yes  No
- Acid reflux?  Yes  No
- Anemia?  Yes  No
- Blood clots?  Yes  No
- Fainting spells?  Yes  No
- Diabetes?  Yes  No
- Kidney disease?  Yes  No
- Pacemaker?  Yes  No
- Joint replacement?  Yes  No
- Latex allergy?  Yes  No
- Oxygen?  Yes  No
- Cancer?  Yes  No
- Chest Pains?  No Yes  Explain: \_\_\_\_\_
- Sleep apnea?  Yes  No
- Hypertension?  Yes  No
- Hepatitis?  Yes  No
- Heart attack?  Yes  No
- Stroke?  Yes  No
- Thyroid disease?  Yes  No
- MRSA?  Yes  No
- VRE?  Yes  No
- Tuberculosis?  Yes  No
- C-diff?  Yes  No
- Mitral valve prolapse?  Yes  No
- Type of cancer: \_\_\_\_\_

Other significant health issues? \_\_\_\_\_

Do you need pre-operative antibiotics? \_\_\_\_\_

**PAST SURGERIES:**

Date:	Type:	Hospital:	Surgeon:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had complications or bad reactions to anesthesia?  Yes  No

List: \_\_\_\_\_

Have you ever had a transfusion?  Yes  No If so, when? \_\_\_\_\_

Have you had a significant weight change in the last year?  Yes  No If so, indicate: gain \_\_\_lbs or loss \_\_\_lbs

Number of pregnancies? \_\_\_\_ Number of children? \_\_\_\_

Do you smoke?  No  Yes, how much: \_\_\_\_\_ Do you drink alcohol?  No  Yes, how much: \_\_\_\_\_

**FAMILY HISTORY**

Have any of these illnesses occurred in your family? Check all that apply and indicate relationship to you:

Illness	Relationship to you	Illness	Relationship to you
high blood pressure	_____	ovarian cancer	_____
diabetes	_____	colon cancer	_____
heart disease	_____	skin cancer	_____
breast cancer	_____	type of skin cancer	_____
<b>other</b>	_____	other	_____

Form completed by \_\_\_\_\_  
(patient's signature)

Relationship to patient \_\_\_\_\_  
(write self if you are the patient)

Nurse Signature \_\_\_\_\_

Physician Signature \_\_\_\_\_