

PATIENT MEDICAL HISTORY FORM

PLEASE FILL OUT COMPLETELY

PATIENT'S NAME:	BIRTH DATE	AGE
-----------------	------------	-----

REFERRING PHYSICIAN:	PRIMARY CARE PHYSICIAN:
----------------------	-------------------------

The information in this section is *REQUIRED* by the Federal Government and must be provided. Thank you.

HEIGHT:	WEIGHT:	PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO	ALCOHOL USE: <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW OFTEN : <input type="checkbox"/> Daily <input type="checkbox"/> Wkly <input type="checkbox"/> Mthly
SMOKER: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> FORMER	# PACKS/DAY:	DRUG USE: <input type="checkbox"/> YES <input type="checkbox"/> NO	STEROID USE: <input type="checkbox"/> YES <input type="checkbox"/> NO	

REASON FOR VISIT:

DATE OF ONSET/INJURY:	INJURY JOB RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
-----------------------	--	---

WHAT MAKES THE PAIN/PROBLEM BETTER OR WORSE?

PRIOR TREATMENT: (Surgery, Physical Therapy, Injections, Medications, Braces)

MEDICAL HISTORY (Circle all that apply - provide explanation in space provided below)

DIABETES HIGH BLOOD PRESSURE HEART CONDITIONS CANCER HEPATITIS / HIV ULCERS / REFLUX ARTHRITIS GOUT

LIST ALL YOUR CURRENT MEDICAL CONDITIONS:

FAMILY HISTORY (Circle all that apply - provide explanation in space provided below)

DIABETES HIGH BLOOD PRESSURE HEART CONDITIONS CANCER ARTHRITIS

LIST ALL YOUR FAMILY HISTORY CONDITIONS & PERSON AFFECTED:

REVIEW OF SYSTEMS/PROBLEMS (Circle all that apply - provide explanation in space provided below)

WEIGHT LOSS / GAIN FEVER / CHILLS HEADACHES EYE / VISION NECK PAIN / STIFFNESS
CHEST PAINS VARICOSE VEINS SHORTNESS OF BREATH WHEEZING / COUGHING
STOMACH / INTESTING URINARY PROBLEMS SKIN / RASH DIZZINESS PSYCHIATRIC

EXPLAIN YOUR CONDITIONS/SYMPTOMS CIRCLED ABOVE:

LIST ALL YOUR PRIOR SURGERIES:

LIST ALL YOUR CURRENT MEDICATIONS (INCLUDE DIETARY SUPPLEMENTS, VITAMINS AND/OR DIET PILLS)

LIST ALL YOUR ALLERGIES / INTOLERANCES: **DO YOU HAVE A SENSITIVITY TO LATEX PRODUCTS?** YES NO

Patient / Guardian Signature	Date
------------------------------	------