Name: _____ Date:_____

Dob: ___/____/____ Age:_____ Height:_____ Weight:_____

Reason for today's visit:_____Date of Injury:_____
Have X-rays been done? Y___N ___ , auto accident? Y____ N_____
Are you pregnant? Y____ N ____

Medical History

Diabetes	Y___ N___	Heart Problems	Y___ N___
High Blood Pressure	Y___ N___	what sort of problems?	
Stroke(s)	Y___ N___	Asthma	Y___ N___
Lung Problems	Y___ N___	Bleeding Problems	Y___ N ___
Kidney Problems	Y___ N___	Liver Problems	Y___ N___
Ulcers	Y___ N___	Cancer	Y___ N___
Thyroid Disease	Y___ N___	If yes , what type of cancer?	
Rheumatoid Arthritis	Y___ N___	Gout	Y___ N___
Scoliosis	Y___ N___	Bronchitis	Y___ N___
Metal Implants	Y___ N___	Seizures	Y___ N___
Pacemaker	Y___ N___	If yes, what kind?	

Any other problems present or past?_____
_____
Please list all previous surgeries:
_____ Year:_____
_____ Year:_____
Do family members, alive or deceased, have any major medical problems?
_____
Drug Allergies:_____
List ALL MEDICATIONS you currently take:
Medication Dose
_____
_____
_____
Marital Status: Single___ Married___ Widowed___ Divorced___
Are you left or right handed?_____
Do you work?_____ Type of work:_____
Use of alcohol: Never___ Rarely___ Moderate____ Daily (amt)_____
Use of tobacco: Never___ Previously, but quit____ Yes (PPD)_____
Do you use any other drugs not listed above?_____

Patient Signature:_____ Date:_____