

PATIENT MEDICAL HISTORY
PLEASE PRINT

PATIENT NAME:	DATE: / /
HEIGHT: WEIGHT: XXXXXXXXXX	AGE: SEX:
CHIEF COMPLAINT:	
MEDICATIONS:	
ALLERGIES:	

FAMILY HISTORY			
HAS ANY RELATIVE EVER HAD?	YES	NO	IF YES, PLEASE EXPLAIN
CANCER			
DIABETES			
TUBERCULOSIS			
HEART DISEASE			
HIGH BLOOD PRESSURE			
STROKE			
HEART ATTACK			
BLEEDING TENDENCY			
PULMONARY DISORDER			
OTHER			

PERSONAL HISTORY			
HAVE YOU EVER HAD?	YES	NO	IF YES, PLEASE EXPLAIN
DO YOU SMOKE?			
DO YOU USE TOBACCO PRODUCTS?			
HISTORY OF SUBSTANCE ABUSE			
PREVIOUS SURGERY			
BEEN SERIOUSLY INJURED			
HAD BACK INJURY			
HAS BACK TROUBLE OR PAIN			
HAD A HERNIA OR RUPTURE			
HAD A HEAD INJURY			
HAD KNEE/FOOT INJURY			
BEEN HOSPITALIZED IN THE PAST 5 YRS			

PATIENT MEDICAL HISTORY CONT'D

PERSONAL HISTORY CONT'D

HAVE YOU EVER HAD?	YES	NO	HAVE YOU EVER HAD?	YES	NO
DIABETES			CHICKEN POX		
HIGH BLOOD PRESSURE			FREQUENT OR CHRONIC COUGH		
TUBERCULOSIS			JOINT PAIN		
HEART CONDITION			EYE PROBLEMS		
CANCER			LOSS OF HEARING		
EPILEPSY			SWELLING OF LEGS OR ANKLES		
HEPATITIS			ANEMIA		
RHEUMATIC FEVER			MUMPS		
SKIN RASHES OR ECZEMA			FREQUENT HEADACHES		
STOMACH ULCER			FAINING/DIZZY SPELLS		
ASTHMA			SHORTNESS OF BREATH		
BLOOD IN URINE			DO YOU WEAR GLASSES?		
PARALYSIS			DO YOU WEAR CONTACTS?		
ARTHRITIS					

THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE

SIGNATURE

_____/_____/_____
DATE