

TOLIVER

PAST MEDICAL HISTORY

PATIENT NAME: _____ AGE: _____ TODAY'S DATE: _____

HEIGHT: _____ WEIGHT: _____ ARE YOU () RIGHT HANDED () LEFT HANDED () AMBIDEXTROUS

WHAT ARE YOU SEEING THE DOCTOR FOR TODAY? _____

WAS THIS DUE TO AN INJURY () YES () NO

IF YES, DATE OF INJURY? _____ DID THIS HAPPEN AT WORK? _____ HAVE YOU FILED A CLAIM? _____

HAVE YOU EVER HAD ANY PRIOR PROBLEMS OR INJURIES TO THE BODY PART/PARTS FOR WHICH YOU ARE SEEING THE DOCTOR TODAY? () YES () NO IF YES, PLEASE EXPLAIN: _____

MEDICAL ILLNESES

DO YOU HAVE OR HAVE EVER HAD THE FOLLOWING:

YES NO

YES NO

YES NO

	ANGINA		CHEST PAIN		THYROID DISEASE
	HEART "ATTACK"		SEVERE HEADACHE		MITRAL VALVE PROLAPSE
	DIABETES		HIGH CHOLESTEROL		IRREGULAR HEART BEAT
	EPILEPSY		HIGH BLOOD PRESSURE		HEPATITIS/ LIVER DISEASE
	KIDNEY DISEASE		HEART DISEASE		BLEEDING DISORDER
	STROKE		DRUG ADDICTION		CANCER
	LUNG DISEASE		ASTHMA		
OTHER: _____					

OPERATIONS

PLEASE LIST ALL MAJOR OPERATIONS AND APPROXIMATE DATE:

1		1	
2		2	
3		3	

MEDICATIONS

PLEASE LIST ALL CURRENT PRESCRIBED MEDICATIONS:

1		1	
2		2	
3		3	

ALLERGIES

PLEASE LIST ANY ALLERGIES TO ANY MEDICATIONS:

SOCIAL HISTORY

YES NO

	DO YOU SMOKE?	IF YES, HOW MUCH?
	DO YOU DRINK ALCOHOL?	IF YES, HOW MUCH?
	IF FEMALE, IS THERE A POSSIBILITY THAT YOU MIGHT BE PREGNANT?	