

PAST MEDICAL HISTORY

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

Height? _____ Weight? _____

Are you { } right handed, { } left-handed or { } ambidextrous

What are you seeing the doctor for? _____

Was this due to an injury? { } yes { } no If so, date of injury? _____

Did this happen at work? { } yes { } no

Have you ever had any prior problems with or injuries to the body part or parts for which you are seeing the doctor today? _____

Medical Illnesses

Do you have or have you had?

yes	no		yes	no		yes	no	
{ }	{ }	Angina, chest pain	{ }	{ }	Mitral valve prolapse	{ }	{ }	Thyroid
{ }	{ }	Heart "attack"	{ }	{ }	Severe headaches	{ }	{ }	Diabetes
{ }	{ }	Irregular heart beat	{ }	{ }	High Cholesterol	{ }	{ }	Epilepsy, stroke
{ }	{ }	High blood pressure	{ }	{ }	Hepatitis/Liver Disease	{ }	{ }	Kidney Disease
{ }	{ }	Heart disease	{ }	{ }	Bleeding disorder	{ }	{ }	Drug addiction
{ }	{ }	Cancer	{ }	{ }	Lung Disease	{ }	{ }	Asthma
{ }	{ }	Other _____						

Does any member of your family have or have they ever had?

- | | | | |
|-------------------------|----------------------|--------------|---------------------------|
| { } Arthritis | { } Heart Disease | { } Diabetes | { } Blood Disease |
| { } High Blood Pressure | { } Muscular Disease | { } Cancer | { } Bone or Joint Disease |

What kind of operations have you had? (When?) { } None

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

List your current medications

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

List any allergies to any medication:

- | | | |
|-----|-----|--|
| yes | no | |
| { } | { } | Do you smoke? – If yes, how much? |
| { } | { } | Do you drink alcohol? – If yes, how much? |
| { } | { } | If female – Is there any possibility that you are pregnant at this time? |