



**MEDICAL HISTORY**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Social Security# \_\_\_\_\_  
 Dominant Hand: [ ] Right [ ] Left  
 Reason for visit? \_\_\_\_\_

Was this a result of an accident? \_\_\_\_ yes \_\_\_\_ no  
 Automobile? \_\_\_\_\_ Work Related? \_\_\_\_\_ Other? \_\_\_\_\_  
 Have you seen a physician in the last 6 months? \_\_\_\_ yes \_\_\_\_ no  
 If yes, Name of physician and what condition you were treated for: \_\_\_\_\_

Allergies: (food / drugs / others) \_\_\_\_\_  
 If yes, please explain: \_\_\_\_\_

Medications: \_\_\_\_\_

Surgical History: (indicate type of surgery and date) \_\_\_\_\_

**Medical History**

	YES	NO	If yes, Describe:
Arthritis	_____	_____	_____
Blood Pressure	_____	_____	_____
Circulation	_____	_____	_____
Diabetes	_____	_____	_____
Heart	_____	_____	_____
Liver	_____	_____	_____
Lungs (asthma, other)	_____	_____	_____
Thyroid	_____	_____	_____
Tuberculosis	_____	_____	_____
Other	_____	_____	_____
Do you smoke?	_____	_____	_____
Substance abuse	_____	_____	_____
Are you pregnant?	_____	_____	_____
Are you HIV positive?	_____	_____	_____

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_