



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: _____