

Medical History Form

Name:	Date of Birth:	Age:	Today's Date:
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Illness or injury for which you are seeking treatment today (accident details): _____ Date of Injury: _____

Was this injury work related? Yes No

Medication Presently Taking:

Allergies and Sensitivities (Certain food, medication, etc.)

Allergic To:	Effect:
_____	_____
_____	_____

Hospitalization, Surgeries

Year:	Operation, Illness, Injury:
_____	_____
_____	_____
_____	_____

Social History

Marital Status: _____ Children: _____

Smoke Cigarettes/Cigars? Yes No If yes, how long? _____

Alcohol? Yes No If yes, how heavy? Heavy Social Occasionally

Female Patients Only

Currently on birth control? Yes No

Currently pregnant? Yes No

Have you ever had any of the following illnesses?

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Muscles, Bones or Joints |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gallbladder Trouble | <input type="checkbox"/> Myocardial Infarction |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Migrain Headaches |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Angina (Heart Pain) |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Cancer of _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Depression/Nervous Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Goiter (Swelling of the Thyroid) |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Hypertension (High Blood Pressure) |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Coronary Artery Disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | |

Other _____
