PATIENT MEDICAL HISTORY

PLEASE PRINT

Patient Name:			**Date: / /**	
Height:	**Weight:**		**Age:**	**Sex: M☐ F☐**
Chief Complaint:				
Medications:				
Allergies:				

FAMILY HISTORY			
HAS ANY RELATIVE EVER HAD?	**YES**	**NO**	**IF YES, PLEASE EXPLAIN**
Cancer	☐	☐	
Diabetes	☐	☐	
Tuberculosis	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Stroke	☐	☐	
Heart Attack	☐	☐	
Bleeding Tendency	☐	☐	
Pulmonary Disorder	☐	☐	
Other	☐	☐	

PERSONAL HISTORY			
HAVE YOU EVER HAD?	**YES**	**NO**	**IF YES, PLEASE EXPLAIN**
Do You Smoke?	☐	☐	
Do you use Tobacco Products?	☐	☐	
History of Substance Abuse	☐	☐	
Previous Surgery	☐	☐	
Been Seriously Injured	☐	☐	
Had Back Injury	☐	☐	
Has Back Trouble or Pain	☐	☐	
Had A Hernia or Rupture	☐	☐	
Had A Head Injury	☐	☐	
Had Knee/Foot Injury	☐	☐	
Been Hospitalized in the Past 5 Yrs	☐	☐	

PERSONAL HISTORY (CONTINUED)					
HAVE YOU EVER HAD?	**YES**	**NO**	**HAVE YOU EVER HAD?**	**YES**	**NO**
Diabetes	☐	☐	**Chicken Pox**	☐	☐
High Blood Pressure	☐	☐	**Frequent or Chronic Cough**	☐	☐
Tuberculosis	☐	☐	**Joint Pain**	☐	☐
Heart Condition	☐	☐	**Eye Problems**	☐	☐
Cancer	☐	☐	**Loss of Hearing**	☐	☐
Epilepsy	☐	☐	**Swelling of Legs or Ankles**	☐	☐
Hepatitis	☐	☐	**Anemia**	☐	☐
Rheumatic Fever	☐	☐	**Mumps**	☐	☐
Skin Rashes or Eczema	☐	☐	**Frequent Headaches**	☐	☐
Stomach Ulcer	☐	☐	**Fainting/Dizzy Spells**	☐	☐
Asthma	☐	☐	**Shortness of Breath**	☐	☐
Blood in Urine	☐	☐	**Do You Wear Glasses?**	☐	☐
Paralysis	☐	☐	**Do You Wear Contacts?**	☐	☐
Arthritis	☐	☐			

THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE

_____ _____/_____/_____

SIGNATURE **DATE**