

**(Please Print)**

**PATIENT MEDICAL HISTORY**

**NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_

**OCCUPATION:** \_\_\_\_\_ **PRIMARY CARE PHYSICIAN:** \_\_\_\_\_

**PREVIOUS SURGERIES:**  None **REFERRED BY:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS:**  None (Include prescription and over-the-counter medications)

Medication	Dose	How Often?

<b>ALLERGIES (Meds or Other):</b>	<b>DO YOU USE TOBACCO?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Packs Per Day:
<input type="checkbox"/> None	<b>DO YOU DRINK ALCOHOL?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes How Much?
	<b>ARE YOU PREGNANT?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Possibly
	Do You Take Birth Control Pills? <input type="checkbox"/> No <input type="checkbox"/> Yes

**HAS ANYONE IN YOUR FAMILY HAD:**

Yes No (family member)	Yes No (family member)
<input type="checkbox"/> <input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> <input type="checkbox"/> Heart disease
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Kidney disease
<input type="checkbox"/> <input type="checkbox"/> Epilepsy/Convulsions	<input type="checkbox"/> <input type="checkbox"/> Mental Illness
<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Thyroid disease

**HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR SYMPTOMS (if so, when)**

Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Heart Problems	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Bladder/Urological Problems
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Kidney Problems
<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Liver Disease/Hepatitis (type: )
<input type="checkbox"/> <input type="checkbox"/> Blood Clots	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Arthritis
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Gout
<input type="checkbox"/> <input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> <input type="checkbox"/> Ulcers/Reflux	<input type="checkbox"/> <input type="checkbox"/> Depression
<input type="checkbox"/> <input type="checkbox"/> Bad Teeth	<input type="checkbox"/> <input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> <input type="checkbox"/> Hearing Difficulty	<input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> <input type="checkbox"/> Communicable Diseases
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Skin Disorders	<input type="checkbox"/> <input type="checkbox"/> HIV
<input type="checkbox"/> <input type="checkbox"/> Antibiotic resistant infection	<input type="checkbox"/> <input type="checkbox"/> Metal allergy/sensitivity	Other Illnesses:

**Is this a work related injury?**  No  Yes **Is there any litigation involved with this injury?**  No  Yes

The above information is true and correct to the best of my knowledge.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

M.D. Review: \_\_\_\_\_

Date: \_\_\_\_\_