PATIENT MEDICAL HISTORY INFORMATION

NOTE - *Thoroughness, accuracy, and honesty will help make treatments better and safer!*

Name:_____ Date:____/____/____

Date of onset of current injury / problem / surgery ____/____/____

Brief description of current problem:_____

If you have had any prior treatment for the current injury / problem / surgery then please briefly describe:_____

Do you now have, or have you ever had any of the following?

DIABETES	YES___NO___	ALLERGIES	YES___NO___
HIGH BLOOD PRESSURE	YES___NO___	PACEMAKER	YES___NO___
KIDNEY PROBLEMS	YES___NO___	SEIZURES	YES___NO___
NERVE DISORDER	YES___NO___	DIZZINESS	YES___NO___
HEART DISEASE	YES___NO___	HEART ATTACK	YES___NO___
FAINTING	YES___NO___	NAUSEA / VOMITTING	YES___NO___
CHRONIC HEADACHES	YES___NO___	HERNIA	YES___NO___
BONE DISEASE	YES___NO___	OSTEOPOROSIS	YES___NO___
RHEUMATOID ARTHRITIS	YES___NO___	HIV / AIDS (Immune Deficiency)	YES___NO___
CANCER	YES___NO___	PREGNANT	YES___NO___
HEAD TRAUMA	YES___NO___	NECK OR SPINE TRAUMA	YES___NO___
FRACTURES	YES___NO___	BOWEL PROBLEMS	YES___NO___
BLADDER PROBLEMS	YES___NO___	METAL IMPLANTS	YES___NO___
CIRCULATORY DISEASE	YES___NO___	LYME DISEASE	YES___NO___
HEPATITIS	YES___NO___	COPD / BLACK LUNG / ASTHMA	YES___NO___
ULCERS / STOMACH PROBLEM	YES___NO___	BREATHING PROBLEMS	YES___NO___
MRSA / Staph Infection	YES___NO___	PREVIOUS SURGERY	YES___NO___
RECENT UNEXPLAINED WEIGHT LOSS OR GAIN	YES___NO___	OTHER Problem	YES___NO___

If YES to any of the above, please describe in appropriate detail:_____

_____

_____

Please list all current medications:_____

_____

_____

Have you had any recent X-rays, CT Scans, MRI's? If YES, please explain the findings as you understand them:_____

_____

Anything else about your condition or general health you want to let us know about? _____

_____

Name:_____ _____Date:_____

MEDICATIONS LIST

Medication	Dose	How Often	Comments