MEDICAL INFORMATION

REFERRED BY ____________

NAME: ______________________________ DATE: ____________________

M _____ F_____ HT. ______ WT. _______ AGE: ____________________

I. A. Describe your problem. ____

____

____

If injury, how did it happen? ____________________________________

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B. Date of injury (if applicable). ________________________________

C. If this is an injury, where did it happen?

______Auto Accident ______Work ______Home ______Elsewhere

D. Are you currently working? ______Yes ______No

If not, how long have you been out of work? ______________________

E. List you occupation ____

II. Medical History (Please circle)

A. Have you ever had any significant medical problems, such as diabetes, high blood pressure, heart attack, stroke, cancer, epilepsy, gout, bleeding disorders, liver or kidney problems, lung problems, arthritis, stomach ulcer, etc?

B. List all past surgical procedures with approximate dates.

C. List all current medications.

D. List all medications you are allergic to or cannot take.

E. Are you Right-handed or Left-handed?

F. List any previous fractures.

G. FOR WOMEN ONLY: Are you PREGNANT or think you could be?

YES OR NO ____

III. Family History:

Mother Age ______

Father Age ______

Siblings Age ______ Age ______ Age ______

Children Age ______ Age ______ Age ______

Significant Family Illnesses:

Heart Disease, Lung Disease, Diabetes, Cancer, Arthritis,

Liver or Kidney Disease, Nervous Disorders

IV: Social History:

Married ____ Single ____ Divorced _____ Separated _____ Widowed _____

Housing configuration:

Do you smoke? Yes or No

Do you drink alcoholic beverages? Yes or No

V: Review of Systems:

HEENT: Headache, Diplopia, Tinnitus, Epistaxis, Dysphagia,

C-P = Chest Pain, Dyspnea, Wheezing, Hemoptysis

G-I: Nausea, Vomiting, Diarrhea, Melena, Hematochezia

N-U: Pain, Burning, Hematuria, Incontinence

N-V: Syncope, Paralysis, Non-Healing Ulcers