PATIENT MEDICAL HISTORY

Patient's Name: _____

Height: _____ Weight: _____

MEDICAL HISTORY: Have you had, or do you currently have any of the following? Please check **all** that apply.

___ No Previous Medical History

___ Diabetes
___ Hepatitis/Liver problems
___ Kidney Disease/Renal Failure
___ Hyperthyroid
___ Hypothyroid
___ Previous Injuries
___ Gout
___ HIV/AIDS
___ Bone/joint disease
___ Rheumatoid Arthritis
___ Osteoarthritis/DJD
___ Asthma
___ Circulatory problems
___ High Blood Pressure
___ Low Blood Pressure
___ Heart Disease/ Heart attack
___ Bleeding Tendency
___ Blood Transfusion
___ Stroke (CVA)
___ Slow to heal
___ Frequent anxiety
___ COPD
___ Leg cramps
___ Shortness of Breath
___ Cancer _____
___ Previous Injuries _____
___ Neuritis/neuralgia
___ Neurologic Disorder
___ Numbness
___ Depression
___ Bipolar Disorder
___ Skin rashes/conditions
___ Stomach Ulcers
___ Weakness/fatigue
___ Low Back pain

Any other problems or conditions **not** listed above:

HOSPITALIZATION AND SURGICAL HISTORY ___ No Previous Hospitalization/ surgeries

List all previous surgeries or hospitalizations: _____ Date: _____

_____

_____

_____

_____

_____

ALLERGIES

___ Aspirin
___ Novacaine (Local Anesthetic)
___ Tape/ Band-Aids
___ Latex
___ Cipro
___ Penicillin
___ Iodine
___ Metals
___ Cortisonc/Prednisonc
___ Food/Shellfish
___ Sulfa
___ Codeine
___ Morphine
___ Other antibiotics _____
___ Environmental _____
___ Keflex
___ Contrast dyes