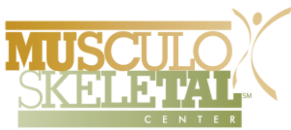

MEDICAL HISTORY

SOCIAL SECURITY #: _________ - _________ - __________ DATE: ____

NAME: ____ AGE: __________________ DOB: _______________________

ADDRESS: ___________________________________ CITY: _______________________ ST: ____________ ZIP: ______________

HOME PHONE #: ___________________WORK PHONE #: ______________________CELL PHONE #: ____________________

OCCUPATION: _______________________________ EMPLOYER: ____

Will this visit be billed to insurance? YES or NO INSURANCE NAME: Primary______________Secondary _____________

GUARANTOR NAME: ______________________________ DOB: __________________ SSN: ____________________________

E-MAIL ADDRESS: ____________________________________ EMERGENCY CONTACT: _______________________________

PHARMACY YOU USE TODAY: ____ PHONE #: ______________________________

REASON FOR TODAY'S APPT: ____ (Please Circle) RIGHT OR LEFT

IS YOUR PROBLEM JOB-RELATED? YES or NO IS YOUR PROBLEM MOTOR-VEHICLE RELATED? YES or NO

FAMILY HISTORY

Have any family members had:			**Who?**
Back Problems………..	Yes	No	________________
Tuberculosis……………	Yes	No	________________
Diabetes………………..	Yes	No	________________
Heart Trouble…………..	Yes	No	________________
High Blood Pressure……	Yes	No	________________
Stroke…………………..	Yes	No	________________
Thyroid Disease……….	Yes	No	________________
Epilepsy………………..	Yes	No	________________
Suicide…………………	Yes	No	________________
Alcoholism…………….	Yes	No	________________
Cancer …………………	Yes	No	________________

INJURIES: **Have you had any**

Broken bones…………	Yes	No
Dislocations…………….	Yes	No
Lacerations (severe)……	Yes	No
Head injury/Concussion…	Yes	No
Neck injury………………	Yes	No
Back injury………………	Yes	No

If yes, explain ____

____

____

Allergies (Medications) ____

____

____

Medications: List all medications & Dosage ______________________________

____

____

____

List all surgical procedures you have had: ______________________________

____

____

List hospitalizations (excluding surgeries) ______________________________

____

____

List physicians you are currently seeing:________________________________

____

____

Weight: Now ____________ 1 year ago __________

Habits: Do you

Sleep well?.................................	Yes	No
Use alcohol………………………	Yes	No
Every day………………………..	Yes	No
Smoke?.......................................	Yes	No

How many packs a day ____________

How many years _________________

PERSONAL HISTORY – ILLNESSES:

Migraine headache……………..	Yes	No
Paralysis…………………………..	Yes	No
Blindness/temporary……………..	Yes	No
Seizures…………………………..	Yes	No
Meningitis………………………..	Yes	No
Pneumonia………………………	Yes	No
Tuberculosis…………………….	Yes	No
Asthma……………………………	Yes	No
Lung disease…………………….	Yes	No
Hives……………………………...	Yes	No
Heart attack………………………	Yes	No
Angina……………………………	Yes	No
Heart failure………………………	Yes	No
Rheumatic fever/murmur…………	Yes	No
High blood pressure………………	Yes	No
High cholesterol…………………	Yes	No
Diabetes………………………….	Yes	No
Ulcers……………………………	Yes	No
Hepatitis………………………….	Yes	No
Kidney disease……………………	Yes	No
Arthritis…………………………..	Yes	No
Thyroid disease…………………..	Yes	No
Radiation therapy…………………	Yes	No
Nervous breakdown………………	Yes	No
Frequent infections……………….	Yes	No
Other major disease………………	Yes	No

____

Patient Signature