Medical History Form

Date ________________________ Physician Signature ________________________________

Name ____ Height _______ Weight _________

Reason for consultation? ____

Are you being seen for an accident related injury? [ ] Yes [ ] No

Type of injury __________________________ Date of injury_________ Work Related?[ ] Y [ ] N

Are you allergic to latex [ ] Yes [ ] No [ ] No known allergies

1. ____________________________________ ____________________________________
2. ____________________________________ ____________________________________
3. ____________________________________ ____________________________________

List Allergies Describe reaction

Current medications: [ ] None

List any prescriptions, drugs, and/or non-prescription medications, including nutritional supplements,

1. _______________________________ ____________________ _________________
2. _______________________________ ____________________ _________________
3. _______________________________ ____________________ _________________
4. _______________________________ ____________________ _________________

List Name of Medications Dose or Strength How Often Taken

Do you use tobacco products? [ ] Yes [ ] No If yes, how much and how long? _______________

Alcohol use [ ] None [ ] Minimal [ ]Moderate [ ] Heavy [ ] Previous User

Previous Surgeries: [ ] None

1. _______________________________ ____________________ _________________
2. _______________________________ ____________________ _________________
3. _______________________________ ____________________ _________________
4. _______________________________ ____________________ _________________

List type of surgery Date Hospital

Have you ever had General Anesthesia (put to sleep)? [ ] Y [ ] N

If yes, describe any problems ____

Pregnancy History: Number of pregnancies _________________

General Medical History: Are you affected by any of the following? [ ]No medical problems

[ ]Heart / Cardiovascular ____

[ ] Lung / Respiratory ____

[ ] Intestinal / Urologic ____

[ ] Muscular / Neurologic____

[ ] Anxiety / Psychiatric ____

[ ]Bleeding Disorders [ ]Hepatitis (type _________)

[ ] Blood Clots [ ] High Blood Pressure