MEDICAL HISTORY

Name _____ Date _____

Drug **ALLERGIES** (hives, rashes, vomiting or unable to breathe): Which medications can't you take?

Medication	Reaction	Medication	Reaction

Habits: Do you now or have you ever used tobacco? NO YES (please complete below)

Type of tobacco _____ _____ Packs per day For _____ years Quit _____ years ago.

Do you drink alcohol? NO YES (please complete below) Type _____

_____ Drinks How frequently _____

Do you use recreational drugs? NO YES (please complete below)

What types? _____ How often? _____

PAST MEDICAL HISTORY: If you, or anyone in your family have had any of these medical problems, please check the appropriate box:

You	Family		You	Family		You	Family	
☐	☐	AIDS/HIV	☐	☐	Drug Abuse	☐	☐	Parkinsons
☐	☐	Alcoholism	☐	☐	Blood Clots	☐	☐	Ulcers
☐	☐	Alzheimers	☐	☐	Fibromyalgia	☐	☐	Peripheral Vascular Disease
☐	☐	Anemia	☐	☐	Gallbladder disease	☐	☐	Renal Disease
☐	☐	Angina	☐	☐	Reflux (GERD)	☐	☐	Rheumatoid Arthritis
☐	☐	Arthritis	☐	☐	Gout	☐	☐	Scoliosis
☐	☐	Asthma	☐	☐	Hepatitis	☐	☐	Seizures
☐	☐	Atrial Fibrillation	☐	☐	High Cholesterol	☐	☐	Sleep Apnea
☐	☐	Benign Prostatic Hypertrophy	☐	☐	High Blood Pressure	☐	☐	Lupus
☐	☐	Cancer	☐	☐	Kidney Disease	☐	☐	Spinal Stenosis
☐	☐	Stroke/TIA	☐	☐	Liver Disease	☐	☐	Spondyloarthropathy
☐	☐	Congestive Heart Failure	☐	☐	Lyme Disease	☐	☐	Thyroid Disease
☐	☐	COPD	☐	☐	Migraines	☐	☐	Heart Valve Disease
☐	☐	Coronary Artery Disease	☐	☐	Multiple Sclerosis	☐	☐	Neuropathy
☐	☐	Crohn's Disease	☐	☐	Heart Attack	☐	☐	Chronic Neck/Back Pain
☐	☐	Degenerative Joint Disease	☐	☐	Obesity	☐	☐	Chronic Pain Syndrome
☐	☐	Depression	☐	☐	Osteoarthritis	☐	☐	Malignant Hyperthermia
☐	☐	Diabetes ☐ Type I ☐ Type II	☐	☐	Osteoporosis	☐	☐	Keloid Scars
☐	☐	MRSA	☐	☐	Other			

_____

OVER

Name _____ Date _____

Past surgical history: Please indicate if you have had any of the following surgeries

	Year		Year
☐ Heart Bypass(CABG)	_____	☐ Hip Replacement	_____
☐ Pacemaker	_____	☐ Hip Surgery	_____
☐ Heart Valve	_____	☐ Knee Replacement	_____
☐ Heart Stent	_____	☐ Knee Arthroscopy	_____
☐ Cancer Surgery	_____	☐ Knee Surgery	_____
☐ Prostate Surgery	_____	☐ Shoulder Replacement	_____
☐ Spine Surgery	_____	☐ Shoulder Arthroscopy	_____
		☐ Shoulder Surgery	_____

Other Surgery _____ _____

_____ _____

_____ _____

_____ _____

REVIEW OF SYSTEMS

Are you currently experiencing any of these conditions:

No	Yes		No	Yes		No	Yes	
☐	☐	Chills	☐	☐	Chest Pain	☐	☐	Skin Infections
☐	☐	Fever	☐	☐	Heart palpitations	☐	☐	Dizziness
☐	☐	Night Sweats	☐	☐	Leg Swelling	☐	☐	Memory Loss
☐	☐	Hearing Loss	☐	☐	Constipation	☐	☐	Numbness
☐	☐	Vision Loss	☐	☐	Heartburn	☐	☐	Cold Intolerance
☐	☐	Cough	☐	☐	Painful Urination	☐	☐	Heat Intolerance
☐	☐	Shortness of Breath	☐	☐	Frequent Urination	☐	☐	Anxiety
☐	☐	Bleeding tendencies	☐	☐	Difficulty Urinating	☐	☐	Depression
☐	☐	Contact Dermatitis	☐	☐	Metal Allergy			