

Medical History Form

lame:	Date of Birth:	
Лedical History: (Please check if you		
Allergies	Eye Problems	☐ Latex Allergies
☐ Anemia	☐ Fainting or Dizziness	☐ Liver Disease or Jaundice
Asthma or Hay fever	☐ Frequent colds/Pneumonia	☐ Loss/Gain of weight
Back problems	Frequent Headaches	Nervous or Mental Disorder
☐ Bladder Trouble	Gallbladder	Pain in Arms or Hands
☐ Bursitis or Shoulder pain	Goiter or Thyroid Trouble	☐ Rheumatic Fever
Cancer, Cysts, or Tumors	☐ Heart Trouble	Rheumatism or Arthritis
☐ Change of Bowel habits	☐ Hepatitis or Cirrhosis	☐ Shortness of Breath
☐ Chest pain or pressure	☐ High or Low Blood Pressure	Skin Trouble or Rashes
☐ Chronic cough or bronchitis	☐ III Effects from Medicine	☐ Swollen Joints
☐ Dermatitis	☐ Indigestion or Heartburn	☐ Varicose Veins
☐ Diabetes	☐ Irregular Heart Beat	☐ Wrist or Elbow Spasm
□ Epilepsy	☐ Kidney or Bladder Disease	·
rgical History & Date/Age if known		1
ospitalizations:	No past hospitalizations:	
ate/Age: Reason:		
ımily History:	History of:	
	Hypertension Heart Disease Stroke	Cancer Unknown
	iabetes Hypertension Heart Disease	
	••	Stroke Cancer Unknown
	• •	Stroke Cancer Unknown
		Stroke Cancer Unknown
	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
ocial History:		
	ner ornever Drug: Yes No Al	
exually Active: Yes No Have y	ou ever had a Sexually Transmitted Diseas	se? Yes No
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edications currently taking (List) Na	me/Dosage/How often:	
lergies: to medications, food, or late	ex (List):	
EMALES ONLY: Is it possible you may	be pregnant? YES NO Date of last Mer	nstrual Cycle:
nmunizations Up-To-Date?To n	ny knowledgeNot up-to-date	Unknown (will discuss w/provider)
jured at Work: YES NO Date/	time of injury:	
oday's Date:		