# Medical History

Name:_____ Date:_____

Please circle your answers on the following questions:

Are you presently working? YES NO Last day worked:_____

Have you ever had these symptoms before? YES NO

If yes, when? _____

Circle those that apply to your current conditions:

Work Related Injury Sports Injury Fall Motor Vehicle Accident Lifting Injury

Aggravation of Pre-Existing Injury Injury Recurrence Causes Unknown Other_____

Do you have, or have you ever had any of the following:

| | | |
|---|---|---|
| Allergies to Heat yes no | Pacemaker yes no | Hypoglycemia yes no |
| Diabetes yes no | Kidney Problems yes no | Asthma yes no |
| If yes, type_____ | Headaches yes no | Bladder Problems yes no |
| Do you take Insulin? yes no | Skin Allergies yes no | Arthritis yes no |
| Allergies to cold yes no | Cancer yes no | AIDS/HIV yes no |
| Seizures yes no | If yes, what type? _____ | Are you Pregnant? yes no |
| Chest Pain yes no | Nausea/Vomiting yes no | Heart Attacks yes no |
| Metal Implants yes no | Ear Ringing yes no | Heart Disease yes no |
| Dizziness yes no | Fractures yes no | If yes, Specifics?_____ |

Have you had any recent falls? YES NO If yes, please explain: _____

If you answered yes to any of the above, please explain and give an approximate date of the occurance:

_____

Is there any other information about your present health that we should know about?

_____

Are you presently taking any medication? Yes No Height: _____ Weight:_____

If yes, please list medicine and dosage_____

_____

_____

_____

Please list Surgical History: _____

_____

Please circle the test you had performed: X-Rays MRI CT Scan Bone Scan Other:_____

Patient Signature_____ Date_____