

MEDICAL HISTORY FORM

Please fill out the following confidential form for our records

Name _____ Today's Date _____

Date of Birth _____ Height _____ Weight _____

Occupation _____ Shoe Size _____

Family Physician _____ and Date of Last Visit _____

Personal Medical History (Please check all that apply to you)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizure Disorders | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Asthma | <input type="checkbox"/> Circulatory Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Gout | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> HIV/AIDS |

Cancer (specify) _____ Other _____

Allergies: (List Type of Reaction Also) _____

Past Surgical History: (List Year of Surgery Also) _____

Present Medications: Please List Medication And Dosage _____

Family History (Parents, Grandparents, Brothers, Sisters)

- Diabetes Hypertension Bleeding Disorder Circulatory Problems

Social History:

Tobacco (Pks/Day) _____ Coffee/Tea (Cups) _____ Alcohol _____

Do you take aspirin daily? _____

Current Problem:

What condition brings you to our office today? _____

When did the problem start? _____

What has been done to treat the problem? _____

Was this a result of an Injury? If yes, describe _____