

MEDICAL INFORMATION

PATIENT NAME _____ Height _____ Weight _____
What part of the body is to be treated? _____ Right _____ Left _____
Date problem started/Date of injury _____ Where did this happen? Work Auto Home Other
Occupation/School _____ Are you off work? No Yes Date last worked? _____
Drug Allergies (None) _____

Allergic to Latex Contrast Dye Adhesives Seafood

Medications (name & dosage) Prescription and Nonprescription (I take no prescription medicines)

List all surgeries (Type of surgery and year)

(I have never had a surgery)

(**Complications**)

General Health

Weight Loss/Appetite change Yes No
Cancer Yes No

ENT& Mouth

Hard of hearing Yes No
Sore throat Yes No
Lump in neck Yes No

Respiratory

Asthma, wheezing, bronchitis, emphysema,
TB or other lung problems Yes No
Shortness of breath after walking one city block Yes No

Skin

Rashes / Lesions Yes No

Bones, Muscles, Joints

Fibromyalgia Yes No
Osteoporosis Yes No

Eyes

Double Vision / Blurring Yes No
Glaucoma Yes No

Comments _____

Cardiovascular

Rheumatic fever, heart murmur Yes No
High blood pressure Yes No
Pacemaker, metal implants Yes No
Heart disease Yes No
Chest pain Yes No
How often: Daily Monthly Yearly
Irregular heartbeat or palpitations Yes No
Heart Attack Date _____

Comments _____

Bladder and Kidney

Kidney failure, dialysis Yes No
Urinary problems Yes No

GI

Frequent heartburn, hiatal hernia Yes No
Hepatitis, Cirrhosis, liver disease Yes No
Ulcers Yes No

Endocrine

Diabetes Yes No
Thyroid problems Yes No

Blood Disorders

Anemia or sickle cell illness Yes No
Hemophilia Yes No
Blood clots Yes No
HIV positive Yes No

Psychological

Depression Yes No

Allergic Immunologic

Rheumatoid arthritis Yes No
Unusual reaction to anesthesia by you
or your family Yes No

Social History

Do you smoke? Yes No
Pack/day _____ Number of Years _____
Do you average 3 or more alcoholic
beverages per day? Yes No
Do you use recreational drugs? Yes No

Neurological

Stroke Yes No
Numbness or tingling in arms or legs Yes No
Convulsions, seizures, fainting spells Yes No

FAMILY HISTORY

If any blood relative has had the following, please circle

- | | | | | | |
|-------------|-------------|------------------|---------------------|-------------------------------|--------------|
| a. Epilepsy | d. Diabetes | g. Anemia | j. Stroke | m. Alcoholism | p. Arthritis |
| b. Migraine | e. Thyroid | h. Bleeds easily | k. Hypertension | n. Cancer | |
| c. Glaucoma | f. Asthma | i. Heart disease | l. High cholesterol | o. None of these in my family | |

THE ABOVE INFORMATION IS COMPLETE AND ACCURATE _____ DATE _____

Patient's Signature _____