PAST MEDICAL HISTORY

(**PRIOR** to the accident/incident if you are here for treatment due to injuries)

NAME: (print) _____ TODAY'S DATE: _____

There is space at the end of this form to write additional comments or for added detail if necessary.

Approximate date of your last physical exam: _____ Did it include: BLOOD ANALYSIS URINE ANALYSIS PAP SMEAR

Results: NORMAL ABNORMAL (list the findings and recommendations): _____

_____

Height: _____ Weight: _____ Realistically, how much do you want to weigh? _____ Are you RIGHT or LEFT hand dominant?

Any surgeries or hospitalizations? NO YES (for what and how long?) _____

_____

Have you ever had treatment to any of these areas: NECK UPPER BACK LOW BACK SPINE NERVE CONDITION SCIATICA OTHER MUSCULOSKELETAL CONDITION: _____

If so, name the condition(s) and briefly explain how it was treated, for how long and did the condition resolve or are there residual problems as a result of the condition: _____

_____

_____

Have you had any x-rays of the neck or spine? NO YES If so, where were they taken: _____

Have you ever been given a disability or impairment rating or do you have a disability: NO YES (explain): _____

_____

Have you ever been knocked unconscious? NO YES (how, how long ago and how long were you out?)_____

_____

Have you ever fractured a bone? NO YES (If yes, what, when and the outcome?)_____

_____

If you have had any surgeries, fractures, accidents, injuries, concussions etc. are there any residual problems or were there any residual complications that you haven't mentioned above? _____

_____

In the past **five years** have you had any problems, conditions or illness in the following areas: HEART/ CIRCULATION HEAD THROAT EYES /EARS/ NOSE/ SINUS STOMACH/ DIGESTION ELIMINATION SKIN ARMS/LEGS REPRODUCTIVE ORGANS

In the past **five years** have you had any problems with: ANXIETY DEPRESSION IRRITABILITY NERVOUSNESS

If so, did you receive treatment or therapy? NO YES If yes, by a: PSYCHIATRIST PSYCHOLOGIST COUNSELOR OTHER:_____ Treated with: MEDICATION BIOFEEDBACK COUNSELING OTHER:_____

Please mark any of the following you have experienced in the last **five years**:

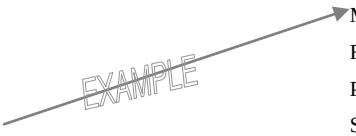
- ☐ unexplained fevers
- ☐ night sweats
- ☐ weight loss over 10 pounds
- ☐ excessive fatigue
- ☐ difficulty sleeping
- ☐ easily bruise
- ☐ excessive bleeding
- ☐ stomach pain
- ☐ lumps in neck
- ☐ swollen ankles
- ☐ persistent/unusual cough
- ☐ skin rashes
- ☐ lumps in breast/arm pit
- ☐ swelling in joints
- ☐ pain in joints
- ☐ dryness in mouth
- ☐ morning stiffness
- ☐ muscle tenderness
- ☐ persistent redness in eyes
- ☐ increased frequency in urination
- ☐ trouble breathing lying flat
- ☐ chest pain/tightness
- ☐ shortness of breath
- ☐ unexplained dizziness or vertigo
- ☐ fainting spells
- ☐ ears ringing or buzzing
- ☐ weight gain over 20 pounds in a one-year period

Please mark any of the following conditions you have **ever** had:

☐ ALLERGIES	☐ DIABETES	☐ HEART DISEASE	☐ ULCERS
☐ ANEMIA	☐ EMPHYSEMA	☐ MISCARRIAGE	☐ CANCER
☐ ARTERIOSCLEROSIS	☐ EPILEPSY	☐ MULTIPLE SCLEROSIS	☐ ASTHMA
☐ ARTHRITIS	☐ GOUT	☐ STROKE OR TIA	☐ _____

Family History: please connect all that apply ☐ UNKNOWN FAMILY HISTORY

HIGH BLOOD PRESSURE
DIABETES
STROKES
CANCER
HEART CONDITIONS
MENTAL/EMOTIONAL DISORDERS



MOTHER, MATERNAL GRANDMOTHER OR AUNT
MATERNAL GRANDFATHER OR UNCLE
FATHER, PATERNAL GRANDMOTHER OR AUNT
PATERNAL GRANDFATHER OR UNCLE
SIBLINGS

How is your appetite? TOO GOOD NORMAL NOT GOOD NO APPETITE

Do you feel you have a well balanced diet? NO YES UNCERTAIN Do you eat a lot of junk food or fast foods? NO YES

Do you eat plenty of whole grains, raw fruits and vegetables? NO YES List the vitamins or supplements you take: _____

_____

Do you smoke? NO YES Packs per day?_____ How many years (total if off and on)?_____ If you quit, how long ago? _____ Do you use other tobacco? _____

Do you drink more than two cups of coffee or two sodas per day? NO YES HOW MUCH? _____

Do you drink alcohol? NO YES If yes, how much: 1 or 2 USUALLY 3 OR MORE How often: _____ days per: WEEK MONTH YEAR

Do you use recreational drugs? NO YES Which ones? _____ How often? DAILY WEEKLY MONTHLY

Do you have good sleep habits? NO YES On average, how many hours per night do you sleep? _____

Do you have a firm mattress? NO YES

Do you do any routine activities? (exercise, walk the dog, tennis, jog etc.) How many times per week and for how long each time? _____

_____

_____

_____

WOMEN:

Any current problems with: SPOTTING INTENSE CRAMPS or PAINFUL MENSTRAL PERIODS BACK PAIN ASSOCIATED WITH PERIOD HEADACHES WITH CYCLE BREAST TENDERNESS OTHER MENSTRAL PROBLEMS:_____

Number of pregnancies: _____ Is it possible you are pregnant? NO YES TRYING UNCERTAIN

Have you had any menopausal symptoms? NO YES UNCERTAIN GOING THROUGH IT BEEN THERE DONE THAT

Are there any other comments regarding your health you want the doctor to know?

_____

_____

_____

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