PAST MEDICAL HISTORY FORM

Patient Name_____Date_____
Date of Birth _____
Are you presently working? YES____ NO ____ Date of next physician visit: _____

1. Date of injury/onset: _____
2. Have you ever had these symptoms before? YES____ NO____
3. Check which apply to your condition:
   _____ Motor vehicle accident: The state injury occurred:_____
   _____ Injury related to lifting
   _____ Athletic/recreational injury
   _____ Cause unknown
   _____ Work-related injury
   _____ Recurrence of previous injury
   _____ Injury related to falling
   _____ Other
4. Have you had related surgery? YES____ NO ____
5. If female, are you pregnant? YES____ NO ____
6. Do you have or have you had any of the following?

	YES	NO		YES	NO
Diabetes	____	____	Hypoglycemia	____	____
Chest pain/angina	____	____	Osteoarthritis	____	____
High blood pressure	____	____	Osteoporosis	____	____
Heart disease	____	____	Hernia	____	____
Heart attack	____	____	Seizures	____	____
Heart palpitations	____	____	Metal implants	____	____
Pacemaker	____	____	Dizziness/Fainting	____	____
Headaches	____	____	Fracture	____	____
Kidney problems	____	____	Surgeries	____	____
Cancer	____	____	Skin Abnormalities	____	____
Stroke	____	____	Nausea/Vomiting	____	____
Bowel/Bladder abnormalities	____	____	Ringing in your ears	____	____
Urine leakage	____	____	Rheumatic arthritis	____	____
Asthma/Breathing difficulties	____	____	Smoking	____	____
Liver/Gallbladder problems	____	____	Other	____	____

If you answered Yes to any of the above items, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.

_____
_____
_____

7. Do you have any allergies? YES____ NO____
   If YES, please list your allergies_____
8. Are you presently taking any medication? YES____ NO_____
   If YES, please list medications and for what conditions:

_____
_____
_____

In case of emergency contact, (name)_____ Phone #_____