# Medical History Form

Name: _____ Age:_____ Date of Birth:_____

Medications and dosages:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies/Reactions:

_____ _____ _____
_____ _____ _____

## Past Medical History

**Do you have or have <u>you</u> had any of the following <u>medical conditions</u>? (Please circle)**

| | | | |
|---|---|---|---|
| Cancer | Kidney Disease | Blood Disorders | Gout |
| Bladder problems | Neurological Disorders | High Blood Pressure | Urinary Tract |
| Infections | Stomach Ulcers | Stroke | Liver Disease |
| Heart Attack | Hepatitis | Tuberculosis | Thyroid Problems |
| Heart Disease | Emphysema/ COPD | Pacemaker | Congestive Heart Failure |
| Asthma | Diabetes | Depression | Anxiety |
| HIV/AIDS | High Cholesterol | Osteoporosis | Psychiatric disorder |
| Arthritis | Rheumatoid Arthritis | Headaches | |

Other:_____

## Surgical History

**Have you had any of the following <u>surgical</u> procedures? (Please Circle and Include dates)**

Back Surgery _____ Neck Surgery _____
Knee Surgery _____ Shoulder Surgery _____
Heart Surgery _____ Other: _____

## Family History

**Does anyone in your <u>family</u> suffer from any of the following <u>medical conditions</u>? (Please circle)**

| | | | |
|---|---|---|---|
| Cancer | Kidney Disease | Blood Disorders | Gout |
| Bladder problems | Neurological Disorders | High Blood Pressure | Urinary Tract |
| Infections | Stomach Ulcers | Stroke | Liver Disease |
| Heart Attack | Hepatitis | Tuberculosis | Thyroid Problems |
| Heart Disease | Emphysema/ COPD | Pacemaker | Congestive Heart Failure |
| Asthma | Diabetes | Depression | Anxiety |
| HIV/AIDS | High Cholesterol | Osteoporosis | Psychiatric disorder |
| Arthritis | Rheumatoid Arthritis | Headaches | |

Other:_____

## Social History

**Social History:** Are you: Married Single Divorced Widowed
Do you smoke? YES or NO Packs per day _____
Do you drink alcohol? YES or NO Drinks per week _____
Do you use street drugs? YES or NO

**Occupation:** Are you working? YES or NO Job Description:_____
Work Restrictions? YES or NO List Restrictions: _____
Do you like your job? YES or NO