

Medical History Form

Name: _____ Age: _____ Date of Birth: _____

Medications and dosages:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies/Reactions:

_____	_____	_____
_____	_____	_____

Past Medical History

Do you have or have you had any of the following medical conditions? (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 surgical procedures? (Please Circle and Include dates)

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

Family History

Does anyone in your family suffer from any of the following medical conditions? (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