MR#

MEDICAL HISTORY

NAME: DATE:

Present complaint:

Date of onset or injury:

Have you had any treatment for this problem? If so, please state:

Who has treated you for this problem?

Current Height: Current Weight:

Are you currently under any Physician's care? Is so, who:

What MEDICAL CONDITIONS are you CURRENTLY being treated for:

List any past surgeries, date, physician & location:

List all CURRENT medication(s) and dosage, including Aspirin:

List any vitamins, supplements and/or any other over the counter medications:

List any allergies to medications:

Do you smoke: YES / NO How much per day:

Do you use alcohol: DAILY / SOCIAL / NEVER

FAMILY HISTORY: (CHECK ALL THAT APPLY)

- □ high blood pressure
- □ heart attack
- □ heart disease
- □ blood disease
- □ lung disease
- □ kidney disease
- □ muscle disease
- □ bone disease
- □ stomach / bowel disease
- □ cancer
- □ nerve disorder
- □ arthritis
- □ diabetes
- □ stroke
- □ seizures