

Please complete this form and bring it with you to your appointment.

NAME (please print) \_\_\_\_\_ DOB: \_\_\_\_\_

**PATIENT'S PAST MEDICAL HISTORY**

Please circle 'yes' or 'no' for the following medical problems as they apply to you, past or present, and explain

 HT: \_\_\_\_\_  
 WT: \_\_\_\_\_

<b>General</b>		<b>Cardiovascular</b>		
Yes	No	Allergy _____ Reaction: _____	Yes No Pacemaker/Defibrillator _____	
Yes	No	Allergy-LATEX _____	Yes No Heart Problems _____	
Yes	No	Birth Defect _____	Yes No High Blood Pressure _____	
Yes	No	Cancer _____	Yes No Stroke _____	
Yes	No	Diabetes _____	<b>Gastro-intestinal</b>	
Yes	No	Diphtheria _____	Yes No Bowel Disorder _____	
Yes	No	Emotional Difficulty _____	Yes No Gallbladder Problems _____	
Yes	No	Epilepsy / Seizures _____	Yes No Hepatitis / Jaundice _____	
Yes	No	HIV / AIDS _____	Yes No Liver Problems _____	
Yes	No	Polio _____	Yes No Reflux Disease _____	
Yes	No	Rheumatic Fever _____	Yes No Ulcer _____	
Yes	No	Scarlet Fever _____	<b>Genito-urinary</b>	
Yes	No	Thyroid Disease _____	Yes No Kidney Problems _____	
<b>Blood</b>		<b>Orthopedic</b>		
Yes	No	Anemia _____	Yes No Arthritis (Degenerative, Rheumatoid) _____	
Yes	No	Bleeding Tendencies _____	Yes No Arthritis (Lupus, Scleroderma) _____	
Yes	No	Blood Clot _____	Yes No Fracture (Broken Bone) _____	
Yes	No	Blood Transfusions _____	Yes No Nerve Compression / Irritation _____	
<b>Respiratory</b>		Yes No Osteomyelitis (Bone Infection) _____	Yes No Spinal Disc Problem _____	
Yes	No	Asthma _____	<b>Miscellaneous</b>	
Yes	No	Lung Disease _____	Yes No Hospitalized _____	
Yes	No	Pneumonia _____	Yes No Other Medical Problems _____	
Yes	No	Pulmonary Embolism (Blood Clot in Lung) _____	Yes No Surgery _____	
Yes	No	Tuberculosis (TB) _____	_____	

 Have you taken Cortisone or Steroid type drugs? Yes No  
 What \_\_\_\_\_ Dosage \_\_\_\_\_ When \_\_\_\_\_

 Do you drink alcoholic beverages? Yes No  
 If so, what type of alcohol? \_\_\_\_\_ Average amount per week? \_\_\_\_\_

 Do you or have you used tobacco products? Yes No  
 If so, what type of tobacco? \_\_\_\_\_ How Long? \_\_\_\_\_  
 Average amount per day? \_\_\_\_\_

 Do you or have you used street drugs? Yes No  
 If so, what kind? \_\_\_\_\_ Average amount per week? \_\_\_\_\_

**FAMILY HISTORY**

If your parents, brothers or sisters have had or currently have any of the following, please circle the appropriate answer and explain.

Yes	No	Allergy _____	Yes	No	Tuberculosis (TB) _____
Yes	No	Cancer _____	Yes	No	Heart Problems _____
Yes	No	Diabetes _____	Yes	No	High Blood Pressure _____
Yes	No	Epilepsy / Seizures _____	Yes	No	Kidney Problems _____
Yes	No	Anemia _____	Yes	No	Arthritis _____
Yes	No	Bleeding Tendencies _____	Yes	No	Back or Neck Problems _____

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_