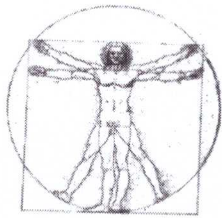

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PAST MEDICAL HISTORY FORM

Patient Name: ______________________________ Date: ____________

Are you presently working? ☐ Yes ☐ No Date of next physician's visit: ___/___/___

Date of injury/onset: ___/___/___ Have you ever had these symptoms before? ☐ Yes ☐ No

Check which apply to your symptoms:

☐ Work related injury ☐ Recurrence of previous injury
☐ Motor vehicle accident ☐ Injury related to lifting ☐ Injury related to falling
☐ Cause Unknown ☐ Athletic / recreational injury ☐ Other: ____________

Have you had related surgery? ☐ Yes ☐ No

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
Chest Pain / Angina	☐	☐	Allergies to Heat	☐	☐
High Blood Pressure	☐	☐	Allergies / Poor tolerance to Cold	☐	☐
Heart Disease	☐	☐	Other Allergies	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heart Palpitations	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐
Headaches	☐	☐	Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fractures	☐	☐
Are you pregnant?	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	Sexual Dysfunction	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Nausea / Vomiting	☐	☐
Urine Leakage	☐	☐	Ringing in your ears	☐	☐
Asthma / Breathing Difficulties	☐	☐	Rheumatoid Arthritis	☐	☐
Liver / Gallbladder Problems	☐	☐	Special Diet Guidelines	☐	☐
Smoking	☐	☐	Hypoglycemia	☐	☐
Stroke / CVA	☐	☐	Other: ____________	☐	☐

If yes on any of the above please briefly explain and give approximated dates:
Is there any other information regarding your past medical history that we should know about?

Are you presently taking Medication? ☐ Yes ☐ No
If yes, please list what medications and for what condition:

Patient Signature

______ Date ____________ Signature of Guardian if patient is a minor ______ Date