



Past Medical History

Patient Name: _____ Date: _____

1. Have you ever had an injury before? Yes No
 If yes, please list your injuries (most recent first):

2. Check which apply to your current condition:
 Athletic injury__ Work related injury__ Injury related to lifting__
 Cause unknown__ Injury related to falling__ Motor vehicle incident__

3. Have you had a surgery related to any of your injuries? Yes No
 If yes, please specify the date:

4. If you are female, is it possible you are pregnant? Yes No

5. Do you have, or have you had, any of the following:

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/ Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Skin Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Urine Leakage	<input type="checkbox"/>	<input type="checkbox"/>	ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Smoking	<input type="checkbox"/>	<input type="checkbox"/>
Liver/Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

6. If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history: _____

7. Do you have any allergies (including medicines or supplements)? Yes No
 If yes, please explain: _____

8. Are you presently taking any medication? Yes No
 If yes, please list the medication and what condition it is for: _____

9. Are you currently taking any nutritional supplements? Yes No
 If yes, please list the supplements and reason for taking it: _____
