ANDOVER
spine & health
chiropractic wellness

MEDICAL HISTORY

Name: _____

CURRENT HEALTH

Do you have additional health concerns related to any of the following?

- ☐ Muscle/Bones/Joints
- ☐ Head/Eyes/Ears/Nose/Throat
- ☐ Diabetes/Thyroid
- ☐ Nursing / Pregnant
- ☐ Headaches/Dizziness
- ☐ Heart/Blood Pressure/Circulation
- ☐ Skin/Bleeding
- ☐ Depression
- ☐ Genital/Bladder/Urinary
- ☐ Stomach/Bowels/Digestive
- ☐ Shortness of Breath/Coughing/Asthma
- ☐ Allergies _____

MEDICAL HISTORY

Do you have a history of heart / circulation problems?	☐ Yes	☐ No
Do you have a history of blot clots?	☐ Yes	☐ No
Do you have high / low blood pressure?	☐ Yes	☐ No
Are there any past illnesses or conditions we should be aware of?	☐ Yes	☐ No
Have you had any surgeries?	☐ Yes	☐ No
In your family history, are there any instances of diabetes, cancer, or other illnesses/diseases we should be aware of?	☐ Yes	☐ No

If yes, please explain: _____

_____

_____

MEDICATION

Please list any medications you are currently taking and the dosage:

_____

_____

_____

This information is complete and accurate to the best of my knowledge.

Signature: _____ **Date:** _____

Andover Spine and Health Center
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