PAST MEDICAL HISTORY FORM

Core Balance
2026 Parkview Ave.
Kalamazoo, MI 49008-2834
Phone 269.775.1551 Fax 269.775.1552
www.CoreBalanceMI.com

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

Have you had a related surgery? ☐ Yes ☐ No

Do you have or have you had any of the following:

	Yes	No		Yes	No
Diabetes	☐	☐	Osteoarthritis	☐	☐
High Blood Pressure	☐	☐	Rheumatoid Arthritis	☐	☐
Low Blood Pressure	☐	☐	Osteoporosis	☐	☐
Chest Pain / Angina	☐	☐	Metal Implants	☐	☐
Heart Disease	☐	☐	Joint Replacement	☐	☐
Heart Attack	☐	☐	Spine Surgery	☐	☐
A Fib	☐	☐	Fractures: _____		
Heart Palpitations	☐	☐	_____		
Pacemaker	☐	☐	Dislocations: _____		
Headaches	☐	☐	Allergies to Tape / Adhesive	☐	☐
Migraines	☐	☐	Allergies to Latex	☐	☐
Kidney Problems	☐	☐	Allergies: _____		
Thyroid	☐	☐	_____		
Bowel / Bladder Abnormalities	☐	☐	Are you Pregnant?	☐	☐
Asthma	☐	☐			
COPD	☐	☐			
Smoking	☐	☐			
Stroke / CVA / TIA	☐	☐			
Seizures	☐	☐			
Epilepsy	☐	☐			

If yes on any of the above, please briefly explain and give approximate date:

Is there any other information regarding your past medical history that we should know about?

Are you presently taking medication? ☐ Yes ☐ No (You may attach a list.)
If yes, please list what medications and for what condition: