Patient's Medical History

Name_____ Birth Date_____
Age_____ Gender M____F____ Height_____ Weight_____ Blood Type_____
Relationship M____S____D____W____ Number of children_____ Pregnant? Y_____ N_____
Occupation_____ Hours per workweek_____
Favorite pastime(s)_____
Emergency contact_____ Phone_____

Please check/list all of the following that apply to you, either presently or in the past:

Major Injuries? N____Y____ explain _____
_____
Major Illnesses/Diseases? N____Y____ explain _____
_____
Any Surgeries? N____Y____ explain _____
_____
Disabilities? N___Y___ explain_____
_____
Heart conditions? N____Y____ explain _____
Liver conditions? N____Y____ explain _____
Kidney conditions? N____Y____ explain _____
Lung conditions? N____Y____ explain _____
Skin conditions? N____Y____ explain _____
Varicose Veins? N____Y____ explain _____
Osteoporosis? N____Y____ explain _____
Arthritis? N____Y____ explain _____
Joint Degeneration? N____Y____ explain _____
Disc Bulge/Herniation? N___ Y___ explain _____
Allergies? N___ Y___ explain _____
Blood Pressure High___ Low___ Normal___ Diabetes? N____Y____ Bruise easily? N____Y____

List any MEDICATIONS you are on: _____
_____
_____
_____

List any SUPPLEMENTS or SPECIAL DIETS you are on: _____
_____
_____
_____

List anything else I should know about your health: _____
_____
_____