MEDICAL HISTORY

Patient's name: ____

My overall health is (circle one): Excellent Good Fair Poor

Please list any and all conditions which you are currently under medical care for: ___________________________

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Please list all current medications you are taking: ____

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Please list any surgical procedures or hospitalizations within the last 5 years: ______________________________

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Please check any of the following that apply to you:

__ Allergies	__ Artificial joint	__ Asthma	__ Bleeding	__ Cancer
__ Chest Pain	__ CRPS (RSD)	__ Diabetes	__ Fibromyalgia	__ Heart attack
__ Hernia	__ Infection	__ Loss of balance/falls	__ Lupus	__ Multiple Sclerosis
__ Neuropathy	__ Night Pain	__ Night Sweats	__ Open wound	__ Osteoporosis
__ Rheumatoid arthritis	__ Shortness of breath/difficulty breathing	__ Stroke/TIA	__ Unexplained weight loss	__ Vertigo

Have you had any imaging or diagnostic testing done for the condition which we are seeing you? If yes, please list: ____

What type of physical activities, hobbies, or recreation do you usually participate in? Please list:

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