

PATIENT'S PERSONAL HISTORY

Name _____ Age _____ Height _____ Weight _____

Family Physician _____ Referred by _____

Have you ever been diagnosed with any of the following? Please circle.

Asthma	Yes	No	High Blood Pressure	Yes	No
Bleeding Tendency	Yes	No	Heart Disease/Attack	Yes	No
Cancer	Yes	No	Heart Murmur/Prolapse	Yes	No
Depression / Mental Illness	Yes	No	HIV/AIDS	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No
Drug/Alcohol Abuse	Yes	No	Seizure Disorder	Yes	No
Hepatitis	Yes	No	Autoimmune Disorders	Yes	No

Do you have a Living Will? Yes No

Other medical problems _____

Do you smoke? Yes No How much? / How long? _____

Do you consume alcohol? Yes No How much? / How long? _____

What medications are you allergic to? _____

Please list prior Surgeries or Hospitalizations _____

Problems or concerns with anesthesia? _____

Family History of Major Illnesses _____

Are you taking any vitamins, minerals or herbs? ... Yes No What _____

Do you take aspirin products? Yes No How often? _____

Any steroids or Cortisone? Yes No

Any blood thinners? Yes No How often? _____

Please list medications and dosage, including over the counter. _____

Is your condition work related? Yes No

Employer _____

Address _____

Telephone # _____ Contact Person _____

Date of Injury _____ Describe how injury occurred _____

Is today's visit related to an auto or other accident? Yes No

Please describe _____

If so, please list name and address of insurance company to receive statement.

Reason for today's visit _____

