Medical History Information

LIST SURGERIES AND DATES:

Primary Physician Name:

Current and past illness /Conditions: Indicate past or present.

☐ AIDS	☐ Cancer	☐ Cardiovascular Disease	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐ Stroke
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐ Joint Replacement
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	☐ Defibrillator
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐ Pregnant

Other:

Family History:

Anemia: Mother ☐ Father ☐ Sister ☐ Brother☐	Scoliosis: Mother ☐ Father ☐ Sister ☐ Brother☐
Arthritis: Mother ☐ Father ☐ Sister ☐ Brother☐	Thyroid Mother ☐ Father ☐ Sister ☐ Brother☐
Cancer: Mother ☐ Father ☐ Sister ☐ Brother☐	Emotional Difficulty: M ☐ F ☐ Sister ☐ Brother☐
Liver: Mother ☐ Father ☐ Sister ☐ Brother☐	Mult Sclerosis: M ☐ Father ☐ Sister ☐ Brother☐
Diabetes: Mother ☐ Father ☐ Sister ☐ Brother☐	Kidney: Mother ☐ Father ☐ Sister ☐ Brother☐
Heart: Mother ☐ Father ☐ Sister ☐ Brother☐	High Blood Pressure: M ☐ F ☐ Sis☐ Bro☐

Alcohol? ☐ No ☐ Yes Drinks per week?	Smoking History? ☐ No ☐ Yes Presently Smoking? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes <u>Hours per week?</u> <u>Light / Moderate / Strenuous</u>

Signature: ______________________________ **Date:** ________________

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

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